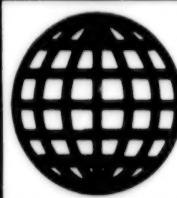


JPRS-TEP-93-010

11 May 1993



FOREIGN  
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# ***JPRS Report***

## **Epidemiology**

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***WORLDWIDE HEALTH***

# Epidemiology

## WORLDWIDE HEALTH

JPRS-TEP-93-010

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11 May 1993

[This EPIDEMIOLOGY report contains material on worldwide health issues. AIDS and other epidemiology topics will be covered in later issues. Comments and queries regarding this publication may be directed to Roberta, FBIS, P.O. Box 2604, Washington, DC 20013.]

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## ANGOLA

### Huambo Province To Get Medicines From RSA

93WE0077B Luanda JORNAL DE ANGOLA  
in Portuguese 16 Oct 92 p 8

[Article by Julio Gomes and Augusto Nunes: "South African Medicine for Huambo"]

[Text] The government of Huambo Province recently spent \$700,000 to purchase medicine from South Africa [RSA], as part of its emergency program for the second half of this year.

Baltazar Manuel, who took over the job of heading the government three months ago, said that the first shipments will start arriving shortly. To this end, two local physicians have gone to South Africa to select the medicine that is going to make it possible to keep the hospitals operating until January. "This time we will be able to get through Christmas and the New Year without major problems," he added.

The purchase of these imports, without going through the usual intermediaries, is based on a request directed to the president of the Republic, since supplies contracted through official channels are never sufficient to meet the pressing needs, and as a result medical care has been rapidly declining.

The other reason underlying this decision has to do with the latest unsuccessful steps taken to provide Huambo hospitals with essential medicines through centralized imports. This resulted in the arrival of unexpected quantities of serum, instead of the medicines needed most.

Baltazar Manuel stressed that: "Health is a sensitive area that has to be included in the initial program of activities of any governor."

"In recent years, despite the promising programs that have been devised, practice has shown that the primary health problems of the people have not been given the attention they deserve," he pointed out.

In fact, the situation is apparent when we look at the fact that at the present time it is difficult to receive any level of treatment in the major hospitals in the province, because of the many shortages. In some cases, patients are seen and receive prescriptions, which they then attempt to fill in pharmacies, in most cases without success, and the diseases end up by taking on alarming proportions.

The people's health conditions have not yet reached disastrous proportions, and the end of military action has contributed substantially to this. For instance, there has been a decline in the number of mental patients at the Central Hospital, which had recorded one of the highest internment rates in 1983.

#### Projects

The building occupied by the central hospital, one of the largest in the country, has needed a general renovation for a long time. The alternative water supply to provide water to various rooms separately from the main system, and the

modernization of the various wards that were heralded so much over the years have been marked by failure.

The many problems of that hospital, which also serves the provinces of Bie, Moxico, and Kuando-Kubango, have meant that the team of physicians and all the staff involved in treatment of the patients have been unable to provide adequate care, primarily in fighting malaria, tuberculosis, and diarrhea.

According to Manuel Baltazar, priority must be given to strengthening the medical sector's ability to provide care through systems of greater impact designed to meet the people's real needs.

The governor has recently been advocating development of the priority sectors, and therefore it is highly possible that the structural and qualitative changes needed to cope with the evident frustration experienced by the people will be occurring some time soon.

#### Social Affairs

"The Provincial Social Affairs Office is currently attending to 6,632 children, 624 of whom have been orphaned and abandoned as a result of the war, and in the next few days they will be participating in job training courses in the areas of carpentry, shoemaking, and tailoring," Hipolito Tchilula, head of that office, said.

This year a gradual reduction in the number of homeless children is expected, since housing is being built in the main towns of the districts, according to the same source. Those persons receiving aid will gradually be transferred to their home towns.

The major concern referred to by this official, who is still worried about the quality of assistance for children, is an improvement in their diet and reduced support from agencies in the sector.

Another important area according to Hipolito Tchilula has to do with the efforts being made to provide the PIC (Community Program for Infants) and the PEC (Community Education Program) with the means to conduct vertical activities, and more important, to improve school programs.

#### Challenges Facing Huambo Hospital Described

92WE0210A Luanda JORNAL DE ANGOLA  
in Portuguese 23 Dec 92 p 3

[Article by Julio Gomes and Augusto Nunes: "Huambo Hospital: History of a Continuing Crisis"]

[Text] Huambo—A project to provide the Central Hospital of Huambo with the basic conditions to curb the evacuation of ailing people to other countries will be resumed when the current military situation changes, a source has told us.

According to the source, the project was conceived in 1988 (in the middle of the period of violent military conflict), and its purpose was to strengthen the technical-material supply system, including the installation of new equipment and interconnections with the various hospital centers in the country.

The plan also called for the continuing maintenance of cadres and direct collaboration between the nucleus of the Faculty of Medicines, the Intermediate Institute of Health, the Institute of Veterinary Research (for questions of microbiology), and the Training Center for basic technicians.

The overall cost of the project was calculated at more than \$5 million and included, in the first phase, the outfitting of the kitchen, the laundry, and the surgical wing.

To execute the project, the provincial government chose the Portuguese firm Eduardo Andrade e Filhos, whose technicians made a study of the needs and presented proposals, which were favorably received and immediately included in the government's action program.

Preliminary indications of the execution of the project were reflected in the acquisition of new equipment for the surgical wing; much of it had already been installed, and it disappeared, along with operating room gowns and masks.

The physicians and mid-level and basic technicians had been introduced to a special supply system, which has not had very good results because of the constant interruptions in the supplies of products and the inability of certain economic agents to keep the stores in operation.

According to the same source, the hospital was also working to improve the moral support system, with the recruitment of highly experienced physicians and with technical and methodological improvements.

While there was progress in some areas, there was no substantial improvement with regard to medicines. The Central Hospital was supplied with medicines through the National Directorate, import "ceilings" from the local government (set at \$200,000 per year) until 1989, and religious and humanitarian institutions.

According to the source, the management of these "ceilings" for the acquisition of medicines in greatest demand was never clear, resulting in maladjustments that were reflected in the quality of the services.

"We had no contact with the suppliers. Normally, the hospital administration took a survey of needs. The list was sent to the Provincial Commission, which selected the importer at its own discretion. So we had no direct control over the situation and this led to diversions of medicines and other irregularities, even to the benefit of some officials in the sector," said the source, who would not cite specific cases.

The ideas to improve the quality of medical assistance began to fall apart with the arrival of countless anonymous letters referring to tribal issues, particularly the issue of "doctors from the north, who had to be removed immediately." The letters resulted in disagreements that thwarted all the good intentions and resulted in the mass withdrawal of the physicians and cadres who were not natives of Huambo.

At this time, the Central Hospital of Huambo is handicapped because of the withdrawal of most of the Angolan and foreign physicians, which is a major problem.

### Sanitarium

The Huambo Central Hospital was founded more than three decades ago. In addition to the central building, its facilities include a mental health clinic, a maternity ward, and a 200-bed sanitarium.

The sanitarium attends cases of tuberculosis, but the number of patients has not been alarming, reflecting a decline in the spread of that disease in the central plateau.

Nonetheless, according to the source, there could be a sharp increase in diseases because of the inadequate medical assistance.

"In recent years we have struggled with the problem of feeding the in-patients. Despite great effort, the nutrition has never achieved positive levels. With the shortage of medicines and the disappearance of some equipment, there will be serious collateral effects," the source concluded.

### MOZAMBIQUE

#### ADEMIMO for Handicapped Veterans Formed

93WE0184A Maputo TEMPO in Portuguese 13 Dec 92 pp 7-10

[Article by Jocelino Sito: "Disabled Veterans Form Association"]

[Text] The Association of Disabled Military and Paramilitary Veterans (ADEMIMO) was formally created for the basic purpose of rehabilitating all those who became disabled in military action and of reintegrating them in Mozambican civilian society.

The constituent conference that culminated in the creation of the ADEMIMO, an association aimed to bring together all the disabled military and paramilitary veterans in Mozambique, took place in Maputo from 16 to 18 November and was attended by delegates from all the provinces in the country. The opening ceremony was attended by Joaquim Chissano, president of the Republic, Defense Minister Alberto Chipande, and representatives of various governmental and nongovernmental institutions.

Speaking on that occasion, President Chissano said the newly created association should be the vehicle to bring together all means necessary to address the concerns and aspirations of the disabled veterans. "The Mozambican society," said the Mozambican head of state, "must support the association in this process of full integration, to avoid the creation of a special, segregated, and dependent group."

Addressing about 160 participants, the president of the Republic stressed that one of the concerns of the Frelimo Party [Mozambique Liberation Front Party] and the government is to achieve a lasting peace and to create conditions so that each Mozambican may exercise his fundamental rights. "Through the ADEMIMO, the disabled veteran must also cooperate in achieving this objective which is so desired by the Mozambican people," Chissano said.

"The disabled veterans must not think that they are the only citizens in the entire society who have sacrificed," the

president stressed, and recommended that they contribute to improving their living conditions and those of their families. In conclusion, Chissano issued a challenge to the ADEMIMO, which is seeking administrative and financial autonomy, to demonstrate to its members and to the society that to be disabled is not to be an invalid.

At this time of implementing the peace, it is perhaps not surprising that the Renamo [Mozambique National Resistance] was represented at the meeting, in the person of Jose de Castro, chief of the Renamo's Foreign Relations Department, who said that he and his organization approved of holding the conference to create an association for disabled veterans. Although they had not received the documents to be discussed in a timely fashion, they demonstrated through their contributions that they are a part of the agenda.

As one of the belligerent parties to the recently ended war, the Renamo has disabled veterans, particularly in Gorongosa, and their delegation was invited to take part in the meeting to create the ADEMIMO. Because of organizational problems, they were not represented in Maputo. However, Jose de Castro, like the other participants, stressed the need for the rehabilitation and reintegration of the disabled veterans in the society.

#### How the Association Was Born

The liberties granted by the Constitution which has been in effect in the country since 1990, including the freedom to form associations, motivated a small group of disabled veterans residing in the Matola Center to broach the idea of creating an association devoted basically to the serious problems that afflict these members of the society.

This group of disabled veterans, who soon formed a nucleus, gathered strength and sympathy from other disabled veterans scattered throughout the country. These veterans felt abandoned, isolated and marginally outside the mainstream. This group, which later came to be called the Central Nucleus, created provincial nuclei throughout the country, to bring about the conditions for the creation of an association.

To achieve this goal, the Central Nucleus concentrated its efforts on motivating all the disabled veterans to take an active part in creating the association and to establish a good relationship with the community. The Nucleus also worked on the preparations for the constituent assembly and on fundraising.

With regard to community relations, during 1991 the Central Nucleus, based in Maputo, did volunteer work in various social and economic sectors. During the period before the ADEMIMO's constituent conference, the provincial nuclei worked with national and foreign agencies to create programs to benefit some of the members.

The above-mentioned programs include a timber-cutting and charcoal-making project financed by the humanitarian organization Carita de Mocambique, and another project for the manufacture of building blocks, financed by the International Committee of the Red Cross (CICV), a world

humanitarian organization. Other projects financed by various humanitarian organizations will soon be initiated in the country, to rehabilitate and reintegrate disabled veterans in the society.

#### Problems With the Functioning of the Nuclei

Although the central and provincial nuclei have struggled for total independence and social reintegration, in developing their activities the members have been abandoned and obliged to obey military orders which prohibited them from demanding their rights from the Defense Ministry. Disabled veterans accuse Defense Ministry officials of relating them to the background and of being more concerned with lining their own pockets.

Because its activities were controlled by the various Defense Ministry structures, the provincial nuclei found it impossible to carry out the established plans in full. Added to the problem has been the lack of funds, without which it has been impossible to establish permanent contacts.

In the final session preceding the closing ceremony, over which Defense Minister General Alberto Chipande presided, the participants in the constituent conference, in a free and democratic vote, elected Virgilio Wenela as president of the ADEMIMO and Constancio Manjeta as vice president of the association that will represent the legitimate interests of the disabled veterans.

The day after the creation of the ADEMIMO, the association met with Defense Ministry officials in what was considered the first meeting in which the officials were presented with the principal problems that face the disabled veterans. According to Virgilio Wenela, among the issues presented and discussed were the rehabilitation of the disabled veterans, their training through the promotion of seminars, and their pensions.

According to Wenela, the pension granted does not include other benefits, such as subsidies for transportation and food, which is a travesty, considering the present cost of living. "Now that we are disabled, we do not receive anything directly from the Defense Ministry, but from the Finance Ministry. Only one transfer was effected," said the president of the ADEMIMO.

#### Amputee Health Care, Rehabilitation Investigated

93WE0184B *Maputo TEMPO* in Portuguese 13 Dec 92  
pp 12-15

[Article by Jocelino Sito: "There Are About 6,400 Amputees in Mozambique"; first paragraph is TEMPO introduction]

[Text] Between 1975 and 1990, in the various health units in the country, about 6,400 people underwent amputations, basically because of infections and war wounds. Of this total, 5,217 amputees lack prostheses.

The results of a clinical study of amputations performed over a 15-year period in the country do not coincide with the estimates that have periodically been presented for Mozambique. In the study conducted by physician Mussa

Calu, those figures, based on almost 30 years of war, were considered to be exaggerated.

The investigation, which made it possible to identify and characterize the greatest possible number of amputees, arose out of the need to provide immediate medical-surgical assistance and rehabilitation to those who had undergone the amputation of one or more members. According to Dr. Calu, his objective is the rehabilitation of the amputees through the restoration of motor functions that would enable them to compete in the labor market.

As part of the U.S. Government support to the efforts of the Health Ministry in the search for solutions to minimize the physical handicaps resulting from the war or other causes, the study was conducted over a period of a year in all the hospital units in the country. Dr. Calu added that at the time the prosthetic assistance program was initiated, there were no reliable data on the number of handicapped people in need of prosthetic devices.

The WHO estimates indicated that about 10 percent of the Mozambican population suffers from one or another disability. This figure includes amputees, most of whom are waiting to receive a prosthetic device. But a number of them are waiting for the extension of the project and the planning of rehabilitation activities.

The study, which was financed by the United States Agency for International Development (U.S. AID), led to the elaboration of a list of amputees by name, their distribution by province, the year in which the surgery was performed, and the present age of the patient.

The investigation was the first complete study conducted in Mozambique, which is why it was necessary to use the existing data from operating room records.

Calu said that much of the data for the years in which the surgery was performed had been lost or destroyed, basically for want of qualified personnel to preserve the records in the files of these health units. This was discovered in the course of the investigation that culminated in the elaboration of the first clinical study of amputees, the results of which were presented in the proceedings of "Health Days VIII," in the middle of October.

The U.S. AID physician, who serves in the Central Hospital of Maputo [HCM], denied that this finding was designed to absolve East European physicians of charges leveled by the people that many of the amputations performed since the country became independent had been forced on the patients by those physicians.

Dr. Calu reacted negatively to the charges leveled against the East European physicians, saying they were untrue, that these specialists had worked selflessly in the cause of saving lives. "The amputations were not forced, although many of them could have been avoided if the patients had been transported promptly to the medical units."

#### Fewer Than Supposed

It is estimated that there are currently 6,400 amputees in the country, a figure that corresponds to the amputees who, by the nature of their wounds, had to be admitted to surgical

units included in the registry of hospitals. It was not possible to estimate the number of civilians who had accidents in the border zones and were admitted to a foreign medical facility.

Dr. Mussa Calu said it was difficult to make an assessment of the maimed who took refuge in neighboring countries because they were blocked up in the zones under the control of the Renamo [Mozambique National Resistance]. The physician said it was possible that many health units had attended and assisted Renamo soldiers who passed themselves off as civilians, and that the same thing had occurred in the orthopedic clinics in the country.

In accordance with the initial purpose of the study, the second important result was the determination of the number of amputees who require a prosthetic device. They are estimated at 5,217, the figure given in the results of the clinical study presented by Dr. Calu. He added that 84 percent of the amputees were civilians and 16 percent were military.

The majority of amputees were males; Maputo, Zambezia, and Inhambane Provinces had the highest number. There were more amputations of lower than upper extremities, and they were largely among peasants, domestic servants, and soldiers. The largest number of amputations occurred in the age group from 16 to 30 and were owing basically to infections and traumatic injuries caused by firearms.

Based on the results of the clinical study, countless investigations could be conducted on the prevention of infections in people who experience accidents, infections that culminate in amputation. According to Dr. Calu, the major factor for the prevention of infection that has emerged to date is peace itself, because a larger part of the state budget will be allocated to the health sector.

The physician said that the end of the hostilities will alter the present health situation, in which patients are not receiving the minimum attention required, transportation to the medical units is not provided promptly, and the supply of antibiotics is inadequate. All of these things have fostered the onset of infection, and added to this there is a shortage of qualified human resources.

Surprisingly, Dr. Calu cited infection as the primary reason for amputation, refuting the popular belief that the major cause is injury inflicted by firearms. In most cases, the trauma is the secondary result of infection in an exposed wound, particularly in rural areas where close contact with nature entails such hazards as snake, crocodile, and other wild animal bites.

#### Production of Prosthetic Devices

The capacity to produce prostheses in the orthopedic workshops in the country more than meets the needs of the amputees, although there are still a large number of disabled who need the devices so that they might be fully integrated in the work force. According to the U.S. AID therapist, attached to the HCM, the life of a prosthetic device is no longer than five years, hence the continuing need for production at around 1,055 devices a year.

The network of orthopedic workshops to meet the needs of the disabled does not cover all the provinces, which makes it difficult for the amputees to be fitted with a prosthesis or to have one repaired, since the majority of them cannot afford the expense of traveling to the orthopedic workshops.

Every day, an unusual number of amputees can be noted coming to the physical therapy department of the HCM for special training, for the purpose of obtaining prosthetic devices. Fernando Assane was injured in October 1990 when he attempted to deactivate a mine which had been laid by Renamo soldiers, when the mine exploded, he immediately lost both arms and one of his legs and received severe face wounds. He said that he came regularly to the health unit.

Artuzinho Geraldo, a resident of the Polana-Canico District, is also a regular visitor to the physical therapy department, for training prior to being fitted with a prosthesis. Geraldo lost one of his legs when he set off a mine in Bela Vista, Matutuine District. He was there visiting his relatives. In the dead of night, men from Afonso Dhlakama's movement burst into the house where he was staying and forced him to go with them.

During the march, they were forced to keep moving forward for a while after they were shaken up by a blast of artillery fire. The accident occurred at about 0300. The soldiers did not give Geraldo first aid until 1300. Only later was he taken to the Central Hospital of Maputo. There were other cases, many of which involved adolescents who had attempted to leap over the barbed wire to the other side of the border.

Mozambique is at peace and a challenge has been launched, with the publication of the results of the first clinical study conducted of amputees in the country. The basic goal is to restore motor function to those who have become disabled under various circumstances.

#### Malnutrition in Urban Centers Increasing

93WE0184C Maputo NOTICIAS in Portuguese  
9 Dec 92 p 8

[Text] The increase in the cost of living in the country, primarily in large cities, such as Maputo, the capital city, is aggravating the problem of malnutrition, particularly among children from birth to five years of age.

During the month of September, according to the nutritional vigilance technician of the Health Ministry, more than 300 children between zero and five years of age were admitted to the Central Hospital of Maputo [HCM] alone.

Ezequiel Cossa said he was concerned about the problem, since, as he said, the nutritional problems are tending to increase.

Other health sources contacted this week also voiced their concern, because the problem is still growing.

Cossa said that, although he did not have precise figures at the time, more children had been admitted to the other three general hospitals in the nation's capital, specifically Chamanculo, Mavalane, and Jose Macamo hospitals, all located on the outskirts of the city.

He said that normally the children who are admitted to the HCM are in an advanced stage of malnutrition and require intensive and special treatment.

The nutritional problem in Maputo and other Mozambican cities is in large part owing to the meager wages paid to most of the workers in the country.

Currently the minimum wage in Mozambique for the tertiary sector is about 60,000 meticals per month, or about \$20. It is estimated that more than 50 percent of the workers in Maputo received the minimum wage, since many companies are bogged down in serious financial problems, the result of poor management and a lack of markets because of the poor purchasing power of most of the population of the country.

Maputo City currently has slightly more than 1.5 million inhabitants and the population of the country as a whole is about 16 million. Recent studies show that more than 60 percent of Mozambicans live in absolute poverty and are among the most suffering people in the world.

The cost of living is such that a kilogram of rice, for example, currently costs more than 1,700 meticals. Even products that were once considered "food for every pocket book," such as white corn meal (Crown brand) now cost from 1,750 to 2,500 meticals per kilogram.

Even sugar, which should be a staple in any household, costs from 2,000 to 3,000 meticals per kilogram. Generally speaking, the so-called basic products are sold at prices beyond the means of most city dwellers whose wage is their only source of income.

Even bread, which is generally considered the "food of the masses," costs between 500 and 700 meticals per loaf, which means that many people are forced to do without this basic food.

A physician attached to the health center of Xipamanine, one of the suburban districts of Maputo, said that from 10 to 15 children a day are treated for problems of severe malnutrition.

The physician, who asked that her name be withheld, said that the worst cases are among the children of people displaced by the war that has devastated Mozambique for the last 16 years and has caused the death of more than a million people.

In all, there are about 4 million displaced people and war refugees. During these past three months of peace, 1,200 Mozambicans have returned, among whom are people who took refuge in neighboring Zimbabwe. The neighboring country of Malawi has the most Mozambican refugees, with about 1 million.

"The nutritional problems are serious, but it happens that they are not taken very seriously, since the displaced people are not receiving the desired assistance because [they do not meet] the criteria established for the purpose," the physician complained.

Ezequiel Cossa also indicated that it is the children of the displaced people in the cities who are most vulnerable to

malnutrition, because these people do not have even the meager wages earned by other families.

A displaced person accused the humanitarian organizations that operate in Mozambique of practicing a discriminatory policy in the distribution of rations.

As proof of this, he noted that they are only concerned with assisting displaced people in the rural areas, disregarding the fact that there are also thousands of displaced people in the cities and, particularly, on the outskirts of cities.

The government is aware of the problems that stem from the meager wages and the increasing cost of living in the country, and it has been attempting some solutions in an effort to alleviate the problem.

For example, in 1990 the government created a fund for assistance to families which are most vulnerable economically, known as GAPVU (Office of Support to the Vulnerable Population).

Prafulla Jaiantilal, deputy director of the institution, reported that the GAPVU had received 18 billion meticals from the government this year, to be used to support these families and other needy individuals, such as undernourished children and elderly people. As a general rule, the beneficiaries of the fund receive 20,000 meticals per month per child, up to a maximum of 100,000 meticals per family.

"The subsidy is offered for a period of one year and can be extended for another six months, depending on the improvement in the condition of the child," Jaiantilal said.

A woman by the name of Balbina Joao, whose son is receiving the subsidy, said the amount is a token contribution because, in terms of the real cost of living, it cannot solve the child's nutritional problems, "which, when all is said and done, the whole family is facing."

At this time, a 400-gram can of milk costs 6,000 meticals.

## SOUTH AFRICA

### Medical Research Council President Retires

93WE0183B Cape Town *THE ARGUS* in English  
25 Nov 92 p 3

[Article by Andrea Weiss]

[TEXT] Dr. Philip van Heerden, who has steered the Medical Research Council through a time of drastic change, is due to retire at the end of the year after four years as president.

Dr. Van Heerden's presidency marked a major shift for the council, which has thrown its weight behind researching the key health problems affecting South Africa.

In his time at the helm, budget cuts forced a 20 percent reduction in staff, which Dr. Van Heerden viewed as "a traumatic experience".

And in that period, major political changes saw the research institute re-enter the international arena both in the northern hemisphere and Africa.

Contact with France, the Scandinavian countries and more formal ties with the United States have been some of the spin-offs of an improved political climate.

There have also been wider contacts with Kenya, Zimbabwe and other African countries.

A graduate of Pretoria University's medical school, Dr. Van Heerden specialized in internal medicine and nuclear medicine at the University of Stellenbosch before completing his post-doctoral research at the John Hopkins Medical Institutions in Baltimore, in the United States.

He served as vice-president for 10 years before taking over as president in January 1989.

Nuclear medicine remains his first love and he will be doing clinical work in that area at Tygerberg Hospital next year.

Dr. van Heerden said that when he took over as president, his idea was for research to be relevant to the country's pressing health problems.

His other objective was to continue building research capacity at medical schools around the country.

Consequently the council decided to target six main areas in need of urgent investigation: urbanization and health, trauma, TB, AIDS, nutrition and malaria.

Dr. van Heerden said the shift was not intended to stifle research initiatives in other areas but to realign the council's priorities.

"The key word is quality," he said. "It is very important to keep our universities at a high level."

But budget cuts caused some of the council's previous areas of research to be gradually shut down—among them the research done on bilharzia.

"We felt that we had established what should be done to decrease bilharzia and it was up to the health authorities to do this. It had become too expensive and we decided to channel the money into areas of greater need."

The new "leaner and meaner" council is still under pressure to provide for researchers to study abroad, and for affirmative action among disadvantaged students.

In order to raise some money it has established a private company, Med-tech. Its profits will be ploughed back into research.

"The good news is that we have managed to get collaboration with non-governmental organizations willing to invest in us," said Dr. van Heerden.

And now with the World Health Organization poised to get actively involved in South Africa, even more opportunities are presenting themselves.

But for Dr. van Heerden the most difficult part of his time as president was overseeing the staff cutbacks.

"I don't want to go through such an exercise again," he said.

But he believes it was swiftly achieved in a "one-off, quick, clean-cut" operation made essential by economic constraints.

He is also confident he will be leaving the council in good hands with Professor Walter Prozesky—"a very able man, a great scientist and a wonderful human being"—who takes over from him in January.

## ALGERIA

### Services at Hospital Centers Said Inadequate

93WE0179A Algiers ALGERIE ACTUALITE in French  
18-24 Nov 92 pp 7-8

[Article by Dr. R. Rayane, M.D.: "What About the Patient?"]

[Text] Is medicine for the patient or for the doctor? Although the title may look provocative, especially to readers in the health professions, that is not the intention.

The article could have been entitled: Is health care organized for the benefit of the patient or the doctor?

The aim of such an inquiry is certainly not to "bash doctors"—that would be missing the point—but rather simply to express an opinion about the organization of the CHUs [university hospital centers] and to show how the mission of the CHU has been distorted under the weight of constraints and needs in care and training, and to serve interests tied to the mandarin class that continues to run rampant and expand its sphere of influence in the Health Ministry.

One would be completely justified in questioning the judgment of those who "endorsed" the conversion of simple frame buildings into university-hospital institutions, in defiance of the most elementary standards of care, training, and sometimes even hygiene. In defiance of the increasingly multidisciplinary demands of modern medicine. In defiance—why not?—of economic realities.

In short, haven't the interests of patient been sacrificed to the benefit of professional and social ambitions that are—to say the least—questionable?

At independence, Algeria had only one CHU. Today there are 10 others around the country.

Ironically enough, operational strengths and shortcomings aside, it is the oldest CHU, Mustapha Bacha, that is best "structured" for care, training, and research. But Mustapha was built more to benefit the colonial population than Algeria's millions.

Since independence, much progress has been made in hospital infrastructure, especially in medical training. Algeria had only 200 doctors at independence; now there are more than 30,000, including several thousand specialists.

Up to the end of the 1970s, training was provided in health facilities already in existence at independence, mostly concentrated in Algiers, Oran, and Constantine: In some cases, facilities had small extensions built mainly for teaching purposes (prefab temporary dwelling units, old chapels turned into amphitheaters, etc.).

In the early 1980s, under pressure from an ever-growing student population, the need to "unclog" the CHUs in the capital, and demands from local authorities in the interior to get their own universities and CHUs, there was an "opening" to the interior. The pioneers were often young assistant professors, followed some years later for the most part by the first docents and professors.

Thus health facilities that were totally unsuitable and sometimes dilapidated were converted summarily into university-hospital facilities.

It should be noted that many docents and professors are quite happy just to have a department of their own. To department chiefs and health administrators it matters little if they must work in in converted cellars, in remodeled dispensaries that in many cases are barely operational, sometimes even without access to other support facilities (radiology, laboratory, etc.).

This has to do with a certain mental outlook, which though still dominant is rather archaic, to wit, that the only reason for a specialist to work at a university hospital center is to become the department chief for that specialty, an accolade that will make his career for life. This is one aspect of the mandarin mentality.

This situation was to be enshrined in the decree-law of February 1986 governing the status of CHUs.

Facilities frequently ill-suited became component units of the CHUs; units were scattered over dozens of kilometers, sometimes even straddling two or three neighboring wilayas!

The same law severed the CHUs, with their mission of providing "high-level" care, from that part of the health sector responsible for providing "primary care." In the field, this dichotomy quickly proved totally irrational from the economic point of view: Resources (ambulances, vehicles, etc.) underutilized in primary care were inadequate for a CHU; duplication of the same service (preventive medicine) in the same area, etc.

This situation is fairly characteristic of CHUs in the interior of the country, and Blida is a typical example.

#### Organization of Blida CHU

Units	Departments	Sites <sup>1</sup>	Wilayas
Blida	Internal medicine, rheumatology, pneumology, hematology, laboratory, emergency room	Blida general hospital (downtown)	
	Gynecology, pediatrics, laboratory, radiology	Ben Boulaïd clinic (Ben Boulaïd suburban development)	
	Surgery, emergency surgery facility, preventive medicine	Mitidja Clinic (Larmaj suburban development)	
Kolea	Internal medicine, nephrology, general surgery, laboratory	Kolea Hospital	Tipaza

## Organization of Blida CHU (Continued)

Units	Departments	Sites <sup>1</sup>	Wilayas
Douera	Internal medicine, cardiology, orthopedics, general surgery, burn victim surgery, rheumatology, laboratory, radiology	Douera Hospital	Algiers

1. The independent departments in the Blida unit are separated from each other by several kilometers, while the three units are separated from each other by several dozens of kilometers.

This CHU is composed of three units, situated in three different towns, belonging to three different wilayas. Each unit is composed of several groups of hospital departments. Each group of departments is located in a different section of town.

It should be added that each unit is administered by a bloated bureaucracy subordinate to another bloated bureaucracy.

However, despite all the units that make up Blida's CHU, it fails to meet the standards set for CHUs in the law (at least nine departments, selected for interdependence and complementarity in covering patients' needs).

The Frantz Fanon hospital, a large, totally independent psychiatric establishment adjacent to the CHU, houses a number of specialized departments (neurosurgery, neurology, ophthalmology, ORL [expansion not given; possibly otorhinolaryngology], functional rehabilitation, anatomopathological forensic medicine, cancer center) built up over the years since 1983 under the above-described conditions.

Even a short tour of the premises gives some idea of the enormous problems in terms of patient care. It is anybody's guess where a traffic accident victim with multiple injuries will end up. Taken to the emergency surgical facility for treatment of lesions, he is transferred to the neurosurgery unit (at Frantz Fanon hospital) for cranial traumas. If limbs are fractured, he will have to be moved to the orthopedic department (in another part of town). And if he cannot be revived, he will need a physician specializing in resuscitation—which might be difficult to find, since the resuscitation department doesn't actually exist, though its (high-ranking) chief has been at his job for more than five years now!

In addition, whenever the patient has to be moved, one must find an ambulance, which is not always available.

Sadly, such problems are not imaginary. They are real and so numerous as to be almost routine in the medical profession.

Indeed, medicine is "ailing" in several important respects. Here we have discussed only one of them, the poor organization of health-care delivery, and primarily the university-hospital system: Its slapdash character, its loss of focus on mission, and the irrational way it has been implemented have cost the state a great deal of money, without addressing the medical needs of the citizenry.

It is not enough to keep demanding more resources. It is time for a systematic reappraisal, with the single aim of establishing a health care system designed for the patient's welfare.

The situation we see in our country requires radical changes in many domains, and health care is one of them.

## Efforts by Health Ministry To Control Birthrate

93WE0269A Algiers *EL WATAN* in French 27 Jan 93 p 5

[Article by Inal-Chafika: "The 'D' Bomb"—first paragraph is *EL WATAN* introduction]

[Text] In recent years, Algeria's population, while still increasing, has nevertheless been doing so at a slower rate.

Already at the beginning of 1992, the Algerian resident population was close to the 26-million mark. In 1991, 773,000 babies were born, which represents a gross rate of 30.10 per thousand; there were 100,000 deaths, i.e., a gross death rate of six per thousand.

## Birthrate Trends

In 1992, there were 5,000 births [sic] in the Algiers wilayah, i.e., 1.6 percent of the annual growth rate.

Every year, Algeria records some 25,000 births [sic].

Most women marry young, except in certain more or less well-educated social strata; hence a high birthrate: on the average 7.4 children for each married woman over 20 years of age and who remains married until age 45 to 49. According to a WHO study, the generations that reach marriageable age are increasingly numerous, which accounts in part for the demographic boom. The gross marriage rate is somehow consistent with population numbers.

As for the age of marriage, it has been considerably postponed, reaching unprecedented levels in 1992: 24 for women, 28 for men.

For certain categories of women, the fertility rate tends to decrease, because they get married later and because contraception is becoming more common. The less fertile women are more likely to live in towns, and to be educated or married to executives.

On the other hand, factors that currently prompt these women to have more children are improved public health conditions and the limitation of the breast-feeding period.

Infant mortality continues to decrease, but not as fast as in previous years.

In 1988, the infant mortality rate was 60.37, compared with 56.86 in 1991.

## Natural Growth

The natural growth rate is said to have been decreasing recently, becoming stabilized at about 3.1 percent per year.

According to official departments, at that rate the Algerian population will double every 20 years. We can thus credit Algeria with a population of 34 million by the year 2005. It is not certain that the birthrate will decline sufficiently fast in the immediate future to reduce Algeria's present natural growth rate.

Anyhow, many specialists believe that this ample growth rate may hinder development. The population is young, and half of it is under 25.

For a long time, the government rejected all birth-control policy, as they believed that the country was rich enough to feed all these mouths.

Recently things have changed. Family planning and birth control are even encouraged. But that does not go very far and has very little effect on the population increase of traditional societies, especially considering that the country's economic development policy relies more on technology than on people.

This leads to increased unemployment, especially among young people; such a phenomenon is hard to bear for longer periods.

Another negative effect of the population explosion is the emergence of shantytowns around urban centers. Housing availability has increased only insignificantly so far.

The risks are serious, especially as a flight from rural areas could not be slowed down significantly through coercive measures, which public opinion would be very unwilling to accept.

If the population continues to grow, this will have an impact on society. By the year 2000, we will need 7.2 million jobs and 4,000,000 housing units to meet the demand.

Currently, there are fears that the trend toward growth, which has been accelerating for several years, will continue. If the trend continues, the population will reach an unbelievable figure!

In view of these frightening figures and the negative impact they would have, the government has decided to make population growth control its priority. Some objectives were also included in the 1993 program:

- Intensified efforts with respect to family planning;
- Improvement in the presentation of contraceptive methods, in the way information is provided to women of a very low sociocultural level. In 1985, 25 percent of women used contraception; this rate rose to 33 percent in 1986 and 42 percent in 1991. So far, over one-half of the women of child-bearing age reject contraception. Some say that it goes against religion; others reject it because it results in conflict with their husbands or with their milieu.

Many have trouble understanding the information provided on television in a classical language that many women do not seem to understand. Others, finally, believe that contraceptive methods are the causes of several fatal diseases, cancers for instance.

The new program relies on midwives, who are better able to communicate with these women and can provide information to them as part of a specific program.

The Health Ministry provides contraceptives free of charge in all PMI [mother and child protection] centers, under their trade names: Adepal, Stediril, etc. Intra-uterine devices are also available upon request at all PMI centers. This is part of the program adopted in Algiers last December, at a seminar between all Directorates of Health and Population (DSP's) and the Ministry of Health and Population (MSP). As 1993 was declared "basic health care" year, the efforts of PMI centers alone will not be enough; hence the need to have operators from all sectors pool their efforts.

The objective of the program for the first quarter of 1993 is to break taboos through sex education, which must take place at all levels, in schools and through parents talking to their children above a certain age, the better to establish prevention. The goal is also to set up PMI centers in all basic health sectors (general hospitals, health centers, treatment rooms). At the national level, 5,000 midwives will be retrained. The objective is to teach contraceptive methods.

The ministry will provide midwives with new instruments for their consultations, such as sterilizers and Scialytic lights (special lamps used during consultations with midwives).

Implementation of the family-planning program will become part of the medical studies curriculum.

The overall objective for 1993 is to exceed 50 percent in the rate of contraception use.

Currently, it is estimated that family-planning campaigns can be effective, because of the crisis.

The economic argument is therefore more convincing today. It is an ambitious program, but its implementation might herald a less distressing economic future.

#### Tuberculosis Up Due to Drug Shortages

93WE0247A Algiers *EL WATAN* in French 24 Jan 93  
p 17

[Article by J. Loukil: "Tuberculosis No Concern"]

[Text] For several months now, there has been talk here and there about a recrudescence of tuberculosis, and rumors have given rise to popular concern, prompting people to ask questions. The main cause advanced to explain the upsurge is the shortage of medicines, which allegedly deprives patients of the indispensable treatment. For some, the only solution is to go to Morocco and buy medications available only for those willing to pay a premium.

Oran—Professor Berrabah, chief of the pneumophthisiology service at the Oran CHU [university hospital center], says straight out that "there is no recrudescence of tuberculosis."

"The general public has been upset over the shortage of medical supplies, or, to be more precise, over what has been called poor planning and distribution of medical supplies to

the regions. The medical corps has sounded the alarm, this has created quite a stir, and this is what has alarmed the population."

A national program to combat tuberculosis was launched in 1968. The spread of the disease was checked. This is shown in the statistics: In 1978, the incidence was one per 1,000 inhabitants; in 1982, 0.7 per 1,000 inhabitants.

The most recent figure advanced by Prof. Berrabah is 0.6 per 1,000 inhabitants, and the rate of infection in the wilaya of Oran is comparable to the national rate.

Tuberculosis is a disease found in Third World countries where social life is characterized by denutrition, poor sanitary conditions, malnutrition, promiscuity, etc. All these factors work together to weaken the organism and increase the individual's susceptibility.

Prof. Berrabah says the shortage of drugs such as Rifampicine, Rifanah, and Azionazim results from lack of national planning. "Medications for tuberculosis are a vital necessity and should have top priority. We need a national health policy on medications. Even independent pharmacies should follow priorities established by the Ministry of Health. A team of doctors in the national specifications commission is at work now preparing all this...."

According to Prof. Berrabah, "we must take into account not only the devaluation of the dinar but also the blacklisting of Algeria by the banks and big multinationals, which on occasion have not hesitated to block contracts."

### Safety of Blood Supply for Donors, Recipients

93WE0262B Algiers *LIBERTE* in French 21 Jan 93 p 3

[Article by Chafik Benguesmia: "Blood Transfusion: What Safety?"]

[Text] Many donors are asking questions and wonder whether giving blood endangers their own health.

Seven-year-old Tarik suffers from a form of blood cancer. His condition requires a 2-liter blood transfusion every day. It takes four or five donors to produce the amount required. At Birtraria hospital, where he is hospitalized, supplies are insufficient. Other patients are in the same situation. Often they have to appeal for help from several transfusion centers to cope with what has become a continuing state of emergency. Open-heart surgery requires a minimum of 10 liters of blood. So does dialysis.

Child delivery also sometimes requires a certain quantity of blood. In cases of the Rh-factor incompatibility (between mother's and child's blood), an "exchange transfusion" or complete transfusion of the newborn's blood must be performed on an urgent basis. The shortage is also evident in emergency cases such as burns or serious gunshot wounds. In the absence of family members, medical personnel or the people who transfer the patient to the hospital are themselves most often the donors in such situations. At the Mustapha CHU [university hospital center] blood transfusion center, Dr. Hamouche explains that the paraphernalia used to collect blood is sterilized and used only once, then discarded as soon as the blood is drawn. Similar safety

precautions are taken in bloodmobiles. "There is no possible risk to the donor," adds Dr. Hamouche.

But the recipient would be subjected to health risks if the donor's blood were not first tested in the laboratory. This may sometimes happen in cases of emergency transfusion, where medics must have recourse to spot donors if supplies of the recipient's blood type are insufficient. Ordinarily, donors are asked to fill out health questionnaires and tested for AIDS, syphilis, and viral hepatitis, to avoid risk of contamination. The lack of information about blood transfusion makes it much more difficult to get blood. There has not been a public awareness campaign in the last six years.

The federation of blood providers is facing financial problems, and a nationwide public awareness campaign would be costly. The investments, donations, and subsidies that have been provided are far from enough to overcome the problems. "We get ridiculously little support from the state," says Mr. Ouhadda, the general treasurer. "Reception facilities are inadequate. In some wilayas, like Tiemcen and M'Sila, there is no transfusion center at all."

"The ministry has never seriously addressed this problem," says Mr. Aktouf, secretary general of the federation. This increases the risk in emergency cases, because help must be sought from other wilayas.

Since there is no risk to donors, the latter should not hesitate to offer their blood. Some people need it to survive.

### Employment Problems Facing Pharmacists Discussed

93WE0202A Algiers *LE SOIR D'ALGERIE* in French 28 Dec 92 p 3

[Article by Omar Haddadou: "Health: Pharmacists Out of Work Are in Despair"; first paragraph is *LE SOIR D'ALGERIE* introduction]

[Text] They believed wholeheartedly in the value of their diplomas. They dreamed of working in a profession that would make it possible for them to take it easy after completing a difficult course of training. The sad reality is that the diplomas that they obtained are only a delusion. In the absence of a policy of dealing with this matter in a coherent way the young pharmacists see themselves as destined to pound the pavement and to experience the problem of being out of work.

Algiers (*LE SOIR D'ALGERIE*)—Unfortunately, the real, social scourge of unemployment no longer chooses its victims. However disparaging it may be, the term "old fossils" is also being applied to qualified young workers holding university degrees who have been cruelly abandoned to swell the ranks of the unemployed.

Their four years of study, a fleeting or indelible memory, remain the most attractive image of the extensive sacrifices that they made to obtain a diploma, which often has led into a dead end.

The Algerian university system continues to award this precious document to its graduates, making it possible for

them to speak up in society and make their mark. Unfortunately, if we may use such a word, their diploma is also a sure way of losing their sense of direction in an immense labyrinth. When these forgotten people are so bold as to question their leaders, illusory statements and promises "rain down" on them, but there is nothing to be done about it. Then in their imaginations they dream of projects that will never see the light of day. Since changing professions is a frequent and well-respected practice, they will be forced to go from pillar to post until they lose hope.

The impact of the economic crisis is such that some of those holding diplomas as pharmacists are ready to work in the most remote areas of the country. These young people only ask to have a place to live. (Do not say this too loud. You risk rubbing them the wrong way.)

On a national basis there are more than 350 pharmacists, the majority of them young women, who find themselves left behind in this way. Like all intellectuals who have been left on the sidelines, life seems to be vanishing in front of them. They had followed the course of training for their profession with high hopes, devoting themselves to science. They often stayed up all night, deep in their books, giving up their leisure hours in exchange for a better future.

But life is cruel. These young pharmacists, despite their knowledge, have no chance of escaping from the ranks of the unemployed. The efforts made at the Ministry of Health and Population and in other institutions to find a solution for their long standing problems have led nowhere.

The well-known answer, "budgetary funds are not yet available," has only worsened the complaints of the young pharmacists, whose situation does not seem to be of interest to the authorities at all.

The abandoned young pharmacists joined together and established the Committee of Unemployed Pharmacists. This was a kind of gesture of solidarity to make their dissatisfaction known.

In August 1992 the president and director general of ENAP-HARM [National Pharmaceutical Enterprise] took the step of proposing the establishment of 167 job openings in the different provinces of the country. The young pharmacists were exuberant at this news, but not for long.

The unavailability of housing, particularly in areas of the country away from the coast, made it impossible to implement this proposal. This caused the young pharmacists to feel desperate. Lydia, one of the young pharmacists, told us: "When I was at the university, I criticized young officials who were leaving the country. Now I realize that this is a final alternative open to us." Yacine and Nadia did not realize that after a long and intensive training period they would wind up being considered "old fossils." They explained: "The material that we covered in class was so intensive that we thought that we would have priority in obtaining jobs."

In the text of the various laws and regulations it is explicitly stated that a pharmacist is authorized to work in laboratories performing medical analyses, in health and preventive,

medical care services, in offices performing analyses of drinking water and food, and finally in the field of cosmetology.

It is quite clear that the new generation of pharmacists is determined to denounce, quite openly, the recruitment of unqualified sales personnel for over the counter dispensaries in order to save money, to the detriment of those holding diplomas.

This is a destructive practice that could have negative repercussions when it involves checking records concerning medications prescribed for those who are ill.

Article 188 of Law 85/05 of 16 February 1985 provides: "The retail distribution of pharmaceutical products will be handled exclusively by specialized distribution units located throughout the country as parts of the health system. In every case each retail unit that distributes pharmaceutical products will be under the supervision of a pharmacist."

Another evident fact that should be mentioned is the illicit practice by opportunists of renting out the diplomas of pharmacists when they establish over the counter dispensaries. Now there seems to be no limit to corruption.

Finally, will the establishment of a pharmaceutical industry, which has been recommended in discussion groups and seminars, be an effective formula for dealing with this problem?

## INDIA

### Poor Report Brings Effort To Improve TB Control

#### WHO Report Reviewed

93WE0250A Bombay *THE TIMES OF INDIA*  
in English 25 Jan 93 p 7

[Article by Sabina Inderjit: "TB Drive Neglected: Report"]

[Text] New Delhi, January 24. Even after three decades, the national tuberculosis programme (NTP) has shown poor results. In fact, it has functioned far below its potential.

In their appraisal report, officials of the World Health Organisation (WHO) and Swedish International Development Agency (SIDA) have noted that "the national tuberculosis control programme has languished with ineffective terms of authority and budgets and an exceptionally low executive position within the ministry of health for such an important disease."

The report, recently submitted to the Union health ministry, has reviewed the present policies, practices and problems in the NTP and recommended organisational, technical and administrative measures to improve it.

While taking note of it, a senior ministry official merely says lack of funds has been a major constraint.

The NTP was formulated way back in 1962. Its major objectives were to prevent TB through BCG vaccination, diagnose cases and provide free and efficient treatment. Of the 446 districts in the country, 387 have been integrated in the TB programme.

However, the burden of combating TB in the country continues to be staggering by any measure. More than half of the adult population (above 14 years) is infected. That is to say, of the 60 percent population (480 million), about 240 million at some point or the other would have symptoms of the infection and would have got treated for other chest diseases.

Every year about 1.5 million cases are notified and there are probably well over 500,000 TB deaths every year. There has been no clear evidence of a substantial decrease of the risk of infection over the past 30 years. And, a poorly functioning programme would be creating chronic cases of TB and drug resistance.

On all fronts, be it case finding, management, drug supplies, treatment or research, there is a dire need for substantial improvement. The review team clearly spells these out only after analysing documents, including epidemiological data and reports of previous evaluations of programmes, interviewing officers of major institutions and making field visits to Gujarat, Uttar Pradesh and Tamil Nadu.

Most important, the management structure at the national level needs strengthening to assume leadership in redefining policies, effectively assisting the states supervising the programme implementation, retraining staff, administering funds and procuring supplies. What surprised some officials was the fact that the programme was under an assistant director-general in charge of TB in the ministry.

The states, too, need to assume their responsibility in the programme management and require reorganisation. It has been found that there is little co-ordination between hospitals and primary health institutions in rural areas and between the different services providing TB care in most urban areas, to ensure the management of TB patients until care.

Improvements in the methods and management of case finding must also take place. In spite of the recognised priority of bacteriology diagnosis and cure of sputum-positive cases to reduce the TB problem, a large proportion of human and financial resources is currently used to treat cases diagnosed on clinical and radiological evidence.

As a result of not identifying new cases correctly and those previously treated patients, some patients may be treated with inadequate regimens. In fact, sputum microscopy examination are done with insufficient standards and microscopy laboratories are inadequately equipped. Worst still, a TB laboratory network assuring equipment, training and quality control is not in place.

As for treatment, rationalisation is required. Currently, there are too many alternative regimens and the conventional ones are of unnecessary long duration (about 18 months) and low effectiveness. This has resulted in patients not going through the entire course and thus not getting cured.

Though short-course chemotherapy regimens (combination of four drugs to be taken for six months) having high-cost effectiveness are being implemented, insufficient priority

has been given in ensuring effective treatment of infectious patients, particularly during the initial intensive phase of chemotherapy.

Besides, the present system of recording and monitoring patient identification and progress during treatment to ensure cure of infectious cases is "seriously deficient." Another important aspect is the supply of drugs which is occasionally interrupted by lack of timely funding and of buffer stocks. Further, the quality of the drugs supplied is not controlled.

The present training system relies mainly on courses of the National Tuberculosis Institute, Bangalore. The state-level demonstration and training centres do not function. Even the district TB centres are not adequately prepared to provide in-service training for the dissemination of policy and standards.

It does not make adequate use of training institutions and the non-government organisations at the state level. Even the curricula at medical colleges do not stress the basic principle of TB control.

Lastly, in spite of extensive national experience in both operational and basic TB search, alternative methods to correct the extremely low proportion of cases diagnosed with bacteriological treatment and cured have seldom been implemented.

### World Bank Aid Sought

93WE0250B *Bombay THE TIMES OF INDIA*  
in English 6 Feb 93 p 22

[Article by Sabina Inderjit: "WB Aid Sought To Combat TB"]

[Text] New Delhi, February 5. With a poor report card on its national tuberculosis control programme, the government proposes to seek \$215 million aid (Rs 645 crores) from the World Bank.

The aid, for a five-year period beginning 1994 will, however, be limited to three states—Rajasthan, Uttar Pradesh and Madhya Pradesh, covering 135 districts and six major cities. The amount sought is phenomenal considering that on an average the Union health ministry's annual budget for TB covering all states has been Rs 13 crores.

The ministry has prepared a project report revising the TB control programme, which has been in existence since 1962. The report may be handed over to a World Bank team, currently in the capital to finalise aid (about \$110 million) for another national health programme—leprosy. While the ministry has fared well in its leprosy control programme, it has failed miserably in the TB programme. On every front, the latter has functioned far below its potential, says a report.

According to the recent appraisal report by agencies involved, a strengthened programme will require increased resource allocations at both the Central and local levels and that revision and expansion of the country's TB programme with external financial assistance would appear to be fully justified.

It may be noted that following the Rs 250 crores World Bank aid under the social safety net last year, the health ministry has allocated an additional Rs 18 crores for the TB programme.

While the implementation of the national TB control programme is undertaken by the Centre and states on a 50:50 basis, the project with the World Bank assistance is to be cent percent centrally-sponsored. The main thrust of the revised strategy is to ensure improved case management and cure of infectious cases.

The project thus lays emphasis on educating the masses on the disease through IEC (information, education and communication) techniques improving the drug delivery system, better supervision and information system and cost-effective efficiency, among other aspects.

Observers, however, are surprised over the ministry's decision to implement the project in these three states. Instead they feel that a single state should have been selected as a model to demonstrate the technical and operational feasibility of the revised strategy. In reply, a ministry official says the three selected states are the most backward and an impact will be made.

Of the \$215 million aid, over half the amount (about \$120 million) is to be spent on anti-tuberculosis drugs. Treatment of TB is expensive. It has been found that Rs 1,425 (\$50) are to be spent on drugs alone per patient. The rest of the aid is for, among other things, equipment, training of staff and IEC.

According to figures available, about 240 million people are infected. About 1.5 million cases are notified every year and there are well over 500,000 tuberculosis deaths every year.

With the threat of AIDS (acquired immuno-deficiency syndrome) spreading in the country, officials are now worried the number of TB cases may go up. Experts note that as aids destroys the patient's immune system he/she is more likely to acquire or reactivate TB. This adds to the urgency of reorienting TB control efforts. Keeping this angle also in mind, observers feel the ministry's plea for aid may be well-taken.

## IRAN

### Taleqani Hospital Angiography Ward Inaugurated

93WE0189B Tehran ABRAR in Persian 14 Dec 92 p 8

[Text] Urmia. JOMHURI-YE ESLAMI. The catheterization and angiography section of Taleqani Hospital in Urmia was inaugurated and began operations.

According to a report by the public relations office of the Medical Sciences University of Urmia, considering the increasing need of the province of Azarbaijan for a center to diagnose heart diseases, with the constant efforts of the president of the Medical Sciences University of Urmia and the cooperation and material help of the officials of the Ministry of Health and Treatment and the office of the Governor General of Western Azarbaijan, the catheterization and angiography section was set into operation in the Taleqani Hospital of Urmia.

According to this report, for the first time, a heart patient was given an angiogram by the medical team headed by Dr. Mehri, a heart and blood vessel specialist.

According to this report, in an interview, Dr. Mehri expressed hope that with the rapid development of treatment resources throughout the province and the university and the installation of the modern equipment that has been purchased, the hard-working and deprived people of Western Azarbaijan will not need to go to other provinces or Tehran for medical care.

It is worthy of note that the catheterization equipment is used for the diagnosis and treatment of hardening of the arteries. With this equipment, the surgeon heart specialist sends a catheter from the thigh arteries to the heart, and while diagnosing hardening of the arteries and openings can widen them.

Previously such patients in the province of Western Azarbaijan went to Tabriz and Tehran to be diagnosed for heart problems.

### Construction of Thalassemia Treatment Center Planned

93WE0189A Tehran JOMHURI-YE ESLAMI  
in Persian 14 Dec 92 p 9

[Interview with the governor of Qa'emshahr by JOMHURI-YE ESLAMI in Qa'emshahr; date not given]

[Text] Qa'emshahr. JOMHURI-YE ESLAMI Correspondent. A thalassemia treatment center will be built in Qa'emshahr.

In a session in the presence of the governor, health and treatment officials, the directors of Vali-ye 'Asr and Razi Hospitals, and several health experts that was held in Qa'emshahr, it was decided that a committee comprised of 10 persons be chosen to attend to the thalassemia patients and their treatment and begin its work.

In the conclusion of this session, the governor of Qa'emshahr, in an interview with our correspondent, announced that a medical testing center for thalassemia patients will be built on a plot of land donated by the late Haj Aqa Mohammadi located in Qa'emshahr and pointed out: According to available statistics, the province of Mazandaran has 2,000 thalassemia patients, of whom 243 live in Qa'emshahr and are being treated in the Vali-ye 'Asr and Razi Hospitals of Qa'emshahr.

## MOROCCO

### Hospital Services, Care at Sidi Kacem Hospital

93WE0274B Casablanca L'OPINION in French  
20 Feb 93 p 4

[Article by Ali Chebibi Quadouri: "Sidi Kacem: Surprise Visit by the Minister of Public Health to the Provincial Hospital in Sidi Kacem"]

[Text] On Thursday, 11 February 1993, at about 1630, Dr. Abderrahim El Harouchi, the minister of public health, paid a surprise visit to our city's provincial hospital. He was

accompanied by his closest associates, including the Inspector General and the director of equipment and materiel.

These visitors were received by:

- Dr. Abdelmajid Bouallou, the provincial delegate
- Dr. Abdellah Bellegmir, the hospital's director
- Mr. Mohamed El Mouharrir, the provincial economic administrator
- Many physicians
- Mr. El Aydi Omar, the general overseer

From the moment he arrived, the minister and the officials who accompanied him undertook a visit to the administration's offices and the various wings of the facility. He listened to complaints from staff and even spoke with patients.

It should be noted that since being named to this position, the minister has frequently made surprise visits so as to see for himself such irregularities as there might be and witness in situ the good or the poor running of the various facilities.

As he (Mr. Minister) could indeed observe, the label of hospital does not agree with its capacity, since a provincial hospital's capacity is in excess of 500 beds, whereas ours is only 210 beds. He noticed that even these 210 beds are not all occupied.

That is due to the fact that a short time ago a second operating room was in full operation (since the 1989 opening, a single room has been working). Technicians (surgeons) cannot dare admit a greater number of patients when they cannot be certain they can serve them all when they cannot shut their doors to emergency cases, something which disrupts all the schedules of our valiant technicians.

To respond to laboratory needs and get more precise analyses, the appointment of a biologist is proving to be very necessary, with a great deal of materiel and products.

It is unfortunate to note that three important technicians (ophthalmology, trauma, and ear, nose, and throat) are in place, but their work is limited to a few consultations, which is due to the shortage of operating equipment.

Nor does resuscitation exist either, and a patient who has been operated on who is prone to the slightest complication is evacuated to Meknes to be resuscitated. Again it should be emphasized that this evacuation, no matter how urgent it may be, requires an ambulance equipped with the needed materiel and products. This vehicle is currently unavailable.

If the materiel arrives in Sidi Kacem in dribs and drabs, staff (ATP) is no longer hired. Thus, since 1989, needs in this staff category were thirty-six (36) and only one-third (12) were filled. In addition to that, those who reached retirement age have left and are not replaced and yet the floor is clean and there is the smell of disinfectant in every corner and department of the facility.

The answer: The poor nurses do the cleaning in addition to the tasks assigned them. This is not right!

After this pleasant visit, during which the minister saw for himself everything that is lacking in equipment and staff, our hope is great that solutions will be found for our hospital as soon as possible.

### Medical Aid to Somalia Reinforced

93WE0274A Casablanca MAROC SOIR in French  
23 Feb 93 pp 1, 2

[Article from MAGHREB ARABE PRESSE: "Morocco Reinforces Its Aid to the Somali People"; first paragraph is MAROC SOIR introduction]

[Text] A shipment of 260 tonnes of food and medicine has already arrived in Mogadishu.

Mogadishu—After two weeks of thorough searching carried out in Mogadishu and the area around Afgoi some 30 km from the capital by patrols from the multinational forces reinforced by reconnaissance flights of American helicopters, during which a major quantity of arms was seized from vehicles and from arms and munitions caches, the situation is starting to calm down and business activity is starting to pick up again with shops and pharmacies reopening. The beginnings of a local police force have also been deployed, and UN vehicles are taking up positions in the city in anticipation of UNSOM [UN Operations in Somalia] II.

This has allowed UN agencies and the multinational forces to resume food distribution operations in the capital in which contingents from Arab and Islamic countries such as Morocco, Pakistan, Saudi Arabia, Kuwait, Tunisia, Egypt, and the United Arab Emirates are taking part.

The Moroccan contingent, which opened a hospital on the Mogadishu University campus for the use of the Somali civilian population, thus filling a huge health gap and for which the second consecutive month is guaranteeing security for citizens on the Baly Dogle highway through the capital as well as moving supplies towards Baidoa, recently reinforced "its humanitarian aid to Somalia with the gift of 260 tonnes of food, 20 tonnes of which are medicines," said Mr. Mehdi Bennani, His Majesty the King's ambassador to Nairobi. A part of this gift arrived through Kenya on board a UN plane belonging to the WFP [World Food Program]. "Other flights are expected to move the rest of this gift," he said, in a statement to Maghreb Arabe Presse [MAP] at the Mogadishu airport.

The food is to be distributed jointly by elements from the contingent and the blue-helmeted UN soldiers, while the medicines will be given to patients in the hospital by the civilian and military medical corps accompanying the contingent. In addition to this gift, since its opening the hospital has been regularly supplied with shipments of medicine from the services of the Royal Armed Forces [RAF] and the Ministry of Public Health so as to save human lives in this country.

The 260 tonnes of supplies and medicines arrived from the kingdom on board a Moroccan ship at the Kenyan port of Mombasa before being sent by air to the Somali capital city's airport, Mr. Bennani explained.

The Moroccan ambassador paid a visit to the hospital, where he listened to explanations by doctors of how the different departments ran and statistics on the traffic it was seeing.

On the same day an airplane from the [RAF] coming from Morocco landed at the Mogadishu airport bringing with it another gift to the Somali people. This time what was involved was a large shipment of clothing including in particular thousands of T-shirts, infant clothing, and other articles of clothing for children, men, and women.

The social affairs section of the contingent, under the command of Captain Fadoua Bennani Baiti, did indeed note that nutrition, health, and clothing problems constitute a set of interlocking issues that are urgent. So it is certain that the contingent from the RAF will ease the distress of the people of Somalia.

At the hospital the number of those seeking treatment exceeded 6,500 in the first 20 days: 1,325 of which were in pediatrics; 1,116 general medicine; 492 dermatology; 401 ophthalmology; 347 in ear, nose, and throat; 305 gynecology; and 170 dental surgery. The number of care-giving acts reached the 3,670 mark, there were 180 laboratory analyses, and 50 X-ray examinations.

Some 29 operations have been performed. "Surgical activity is based on two components: scheduled surgery and emergency cases," Captain Dr. Mohamed Boughalem, an anesthesiologist, said in a statement to MAP. "There is a weekly, preset schedule of operations for scheduled surgery, frequently interrupted by emergency surgery (ballistic trauma, pathological trauma, injured abdomens, etc.)," he added, emphasizing that the anarchy of traffic in the city, despite the reduced number of vehicles, remains the cause of serious accidents.

Furthermore a mobile health brigade provided care to several patients who could not come to the hospital, in Mogadishu and its environs. Frequently this involves Somali citizens who live in small huts where hygienic conditions are completely lacking. Each hut is home to a family of seven to 10 people. The sick suffer from infected wounds with many abscesses, sometimes fistulas, pulmonary or gastrointestinal infections, etc. These patients have benefitted from medical treatment and advice on the use of medicines. With regard to wounds and abscesses, which need both general and local care, these demonstrations of basic needs to ensure the cleanliness of the body and in particular of the affected part of the body were carried out by Dr. Khalid Benrahal before an elite of young people belonging to the camps. Dr. Benrahal, who led the brigade, also gave advice to these young people on how to improve hygiene with locally available means, viz. opening the huts to let in sun, carrying out "litter," and collecting garbage, then burning it away from the camps.

Some camp residents told MAP they had never seen a foreign doctor here. Certain European journalists who followed the operation reported the same thing.

Furthermore, the Moroccan hospital in Mogadishu continues to receive foreign visitors, among them military officials and journalists.

"I was very impressed by what I saw. These people need aid and the number of sick people you are treating is very impressive; you are doing a great service for the Somali people," Kimberly Simon, an American military journalist, told MAP.

"I see that the hospital is very complete, with several very well-organized departments, and I'm sure you're performing excellent work to help these poor people," said Commander Martin Culp, the chief of public affairs with the American armed forces in Somalia, as he ended a visit to the hospital.

"I was impressed by the surgery performed on a wounded Somali who had been hit by a bullet in the liver," he added.

## SAUDI ARABIA

### Health Costs Exceed \$8 Billion Annually

93WE0129A London AL-HAYAH in Arabic 9 Nov 92  
p 15

[Report from Riyadh: "Saudi Arabia Invests \$8 Billion in Health Care Annually; Health Services for Everyone in Saudi Arabia by 2000"]

[Text] The "Health Services for All By 2000" slogan adopted by the World Health Organization [WHO] will become a reality in Saudi Arabia before this century ends, according to the five-year health development plan for 1990-95, which focuses on primary health care.

Interviewed by AL-HAYAH in connection with the Saudi Health Care Exhibition 1992, which opens in Riyadh the day after tomorrow, Dr. 'Uthman 'Abd-al-'Aziz al-Rabi'ah, deputy under secretary of health for planning and research, said that the thrust of the plan is to make the three levels of health care—prevention, treatment, and rehabilitation—available to all citizens. The figures he cited indicate that Saudi Arabia expends more than \$8 billion on health care annually.

In addition to the Ministry of Health, health care is also provided by the military sector, by universities, by the royal authorities of Jubayl and Yanbu', and by the Red Crescent. School health services are offered by the Ministry of Education, and rural health services are offered by the Ministry of Rural and Municipal Affairs. Health services are also available through the private sector.

Dr. Muhammad al-Bakr, director general of planning at the Ministry of Health, told AL-HAYAH that Saudi Arabia currently has one physician for every 900 residents and one nurse for every 400 persons. The number of hospital beds has risen to 41,700, or one bed for every 3,200 people. New hospitals and health centers that will be constructed before the [5-year] plan ends in 1995 will add about 5,240 more beds. The plan also calls for 14 health depositories, three institutes, and four health colleges in Riyadh, Jiddah, al-Dammam, and Abha. The development of health services in Saudi Arabia is reflected in the country's life expectancy, which has risen from 66 years in 1983 to 68 years in 1990.

### Levels of Care

Health care in Saudi Arabia involves 1,702 health centers, which are part of an effective health information system that revolves around family health registers that tie each family to the health center in its area of residence.

Furthermore, the centers, which are the primary providers of health care in Saudi Arabia, are linked to a precise system of referral to hospitals which provide the second level of care. Coordinating bureaus refer patients in need of specialized care to specialized hospitals, which represent the third tier of health care providers.

An important strategic objective of the plan is to make appropriate health care available to population segments that are more at risk, such as mothers, infants, seniors, and those with chronic diseases. Constant advances here are reflected in the fact that the ratio of pregnant women who receive professional health care has risen from 61 percent in 1985 to 86 percent in 1990. The ratio of those who receive birthing care has also risen from 74 percent in 1983 to 90 percent in 1990. The ratio of infants immunized against the six children's diseases climbed to 89 percent in 1990 and is reflected in diminishing mortality rate among children less than five years of age, which has decreased from 113 deaths per 1,000 newborn in 1976 to 34 deaths per 1,000 in 1989.

Two new aspects of health care in Saudi Arabia involve attracting the voluntary participation of citizens and the focus on environmental issues, otherwise known as environmental reform. Friends of Health committees participate in the activities of more than 90 percent of all health centers in certain regions such as Riyadh, al-Baha, Madinah, 'Usayr, Nijran, and Jizan. This ratio climbs to 100 percent in the villages. The same holds true of environmental reform, where coordination between health centers and local communities on environmental issues amounts to 100 percent in Riyadh, Ra'if, al-Jawf, and the villages.

Female participation in health services is rising markedly in Saudi Arabia. Dr. Salih al-Tuwayjri, director-general of training at the ministry of health, told AL-HAYAH that the number of female Saudi doctors employed by the ministry has risen from 314 physicians in 1986 to 666 female physicians in 1991. The number of female technicians also rose from 1,044 in 1986 to 2,474 in 1991. Women account for more than 20 percent of all physicians in the kingdom, and Saudi nationals account for more than 44 percent of all female physicians. Female nurses account for about 80 percent of all nursing staffs and about 9 percent of female nurses are Saudi. Dr. al-Tuwayjri believes that a long way still remains to go before accomplishing the objective of

wide-scale female participation in the health field because of the accelerating speed of adding new facilities in the kingdom.

### Middle Expertise

In return, there has been a true jump in a field that receives the highest priority of Saudi health policies. Dr. Sa'id al-Zahrani, director general of health institutes, told AL-HAYAH that the number of health institutes rose from only seven in 1975 to 37 in 1991. Of the latter, 17 are institutes for men and 20 for women. The number of students rose in the same period from 154 men and women to 6,481. The number of graduates climbed from 281 to 1989.

Offerings at these institutes cover a wide area ranging from nursing, natural healing, radiology, and pharmacy, to dentistry and anesthesiology. Four-year secondary health institutes are the basic vehicle for paraprofessional expertise and accept only those with at least a middle school diploma. The institutes are backed by specialized training programs that offer diplomas and by junior health colleges that offer associate degrees in the health sciences. Curricula offered by those institutions focus on applications and are augmented by hospital training programs.

### Dentistry

Health services also include the prevention and treatment of oral or dental diseases. Dr. Mamduh Nusair, an expert at the dentistry department of the ministry of health, told AL-HAYAH that work is afoot to map dental and oral diseases throughout the kingdom. The project, carried out in cooperation with WHO, involves comprehensive surveys of specific age groups conducted by medical teams under the supervision of ministry of health experts.

The incremental dental care program, which is entering its fifth year, will gradually cover all primary school students for diagnosis and treatment. Some 300,000 Kits containing toothbrushes, fluoride toothpaste, small mirrors, and plaque revealing tablets have been distributed to all fourth-grade students under a program to raise health consciousness.

Water is being fluoridated throughout the kingdom. This includes the main sources of water at desalination plants, which are supervised by the Ministry of Agriculture and bottled potable water, which is supervised by the Ministry of Commerce.

Preventive programs are backed by treatment programs carried out by more than 1,150 dental clinics throughout most of the kingdom. There are some 12 centers specialized in dentistry in addition to 150 roving dental clinics that treat students at their schools, the aged, and residents of remote areas unable to travel to dental facilities.

**German-Kazakh Partners to Build Vaccine Plant**  
93WE0259F Almaty KAZAKHSTANSKAYA PRAVDA  
in Russian 26 Nov 92 p 1

[Article by Murat Buldekbayev: "Vaccine for Children—From KRAMDS"]

[Text] The amount of BCG [not further identified] vaccine imported into Kazakhstan by the Medical Center-KRAMDS [not further identified] Joint-Stock Company is enough for 600,000 injections. It was supplied by Germany's ELTRA.

The vaccine is intended for immunization of newborn infants, usually on the fifth day after birth. It protects the infant's organism from tuberculosis.

All of the quantity of BCG received was transferred free of charge to the republic's Ministry of Health, which will distribute it among maternity hospitals.

This is the first step in a plan for long-term cooperation with ELTRA. Construction of plants in Almaty producing vaccines, sterile fluids and medical equipment was planned during negotiations between the Medical Center-KRAMDS Joint-Stock Company and the German partners. These products will be channeled primarily into the rural division of public health.

**Tartu Agro-Bio Firm To Make Vaccines**  
93UN0516D Tartu POSTIMEES 27 Nov 92 p 3

[Article by Vilja Kallaste: "Soon There Will Be Enough Vaccine For the Whole Baltic Region"]

[Text] At two o'clock yesterday afternoon, the production plant of Eesti Agrobiokeskus [The Estonian Agro-Bio Center] was introduced to the state-level commission visiting Tartu.

Jüri Kumar, director of the Agro-Bio Center told POSTIMEES yesterday that the production plant was set up with the idea that we have enough knowledgeable people in Estonia, who are capable of developing and producing animal vaccines.

The plant of the Agro-Bio Center will be producing vaccines for animals. Laboratory samples of vaccine have already been prepared against red fever in swine and, by mid-December, the Rõõmu Street plant should be producing vaccine and serum against red fever. In the course of the operations, vaccines and serums for other diseases will be added, as science permits, and market demand warrants.

Jüri Kumar thought that, by the middle of next year, the Tartu plant can produce enough red fever vaccine for all the Baltic countries. Cooperation is maintained with colleagues in Lithuania and Latvia so as not to duplicate each other.

The production plant employs five to six people. The Tartu vaccines sell significantly below world market prices, but a little higher than those produced in the East.

**Concern Over Health Condition of Refugees**  
93WE0264B Helsinki HELSINGIN SANOMAT  
in Finnish 4 Feb 93 p 5

[Article by Jorma Rotko: "Parliament Members Took Medicine to Estonia"]

[Text] Last Wednesday, three Finnish members of the Eduskunta visited Kurds living in the Manniku refugee compound. There a building still houses more than 50 Kurds. Accompanying the group were a physician, a nurse, and a van filled with medical supplies.

The delegation visiting Manniku consisted of Vice Chair Saara-Maria Paakkinnen (Social Democrat) and the Green Party members Ulla Anttila and Pekka Haavisto. Ms. Anttila described the sanitary conditions as "terrible."

The refugees may come and go as they please. The front of the building is patrolled by Estonian police, but they told us that they are only attempting to ensure that no unauthorized people get into the building.

The Finns wanted contact with the Estonian Red Cross but were unable to reach any of its representatives.

The Kurds in Manniku have anxiously followed negotiations between Estonia and Russia regarding the return of the Kurds to Russia. That is something they do not want.

Nobody can say how many refugees there are in Estonia. They have arrived from both Russia and Latvia. According to Estonian officials, Kurdish refugees are only a minor problem compared, for example, to Russians, who cross the border and disappear among the 600,000 Russians already residing in the country.

Citizens of Iraq, Iran, and Somalia are now allowed into Estonia only after acquiring a visa in advance from an Estonian consulate.

**Sharp Increase in Chernobyl-Related Cancers Predicted**

93WE0259D Moscow NEZAVISIMAYA GAZETA  
in Russian 5 Feb 93 p 1

[Article by Nikolay Ulyanov: "Doctor Gayle's Gloomy Prediction: The Number of Cancer Patients May Rise Sharply in Russia"]

[Text] An international fund-raising lottery called "Children of Chernobyl," established by Russia's State Chernobyl Committee and Moscow's regional Soyuz-Chernobyl organization with the technical assistance of America's GeoLotto International, Inc., was unveiled yesterday at Moscow's Slavyanskaya Hotel. The main goal of the lottery, which was brought into being by a Russian Federation government regulation dated 30 July 1992, is to attract hard currency and rubles from other than budget sources for the needs of the victims of the Chernobyl tragedy. The new lottery differs somewhat from ones traditional to Russia. First of all it is played with hard currency (the cost of a ticket is one U.S. dollar). The main reason for this innovation is to make the project inflation-proof. Second, it brings together three of the most popular types of games in Russia—instant

lottery, television game shows of the "Field of Miracles" type, and a modified version of "Lotto Million."

Doctor Robert Gayle, vice president of a California group for quick medical response to situations associated with radiation leaks, was present at a press conference held on the occasion of the lottery's opening. In 1986 he was invited by the Soviet government to provide medical assistance to victims of the accident at the Chernobyl Nuclear Power Plant. Yesterday Doctor Gayle shared with reporters the results of his six years of research on victims of the Chernobyl tragedy. In his words, he and his colleagues treated 499 Chernobyl victims transported to Moscow. Of them, 29 died, and the rest are still under observation. A very precise means of determining radiation dose was developed by the doctors in the course of treatment—based on the tooth enamel of patients. This method has been tested out, and it appears to be very promising. The American doctor also feels that in the next 10-12 years Russia may experience a sharp increase in cancer among young people who were 5-10 years old at the moment of the nuclear power plant accident.

### Russian Official on Deteriorating Public Health

93WE0259C Moscow RABOCHAYA TRIBUNA  
in Russian 10 Feb 93 p 2

[Article: "There Will Be No Healthy People in Russia"]

[Text] Vasiliy Romanov, deputy chairman of the Federation of Independent Trade Unions, announced at a meeting of the coordinating council of Russia's Federation of Commodity Producers that according to information he possessed on the health of the nation, by the year 2000 there will be no healthy people in Russia. This in his opinion is the result of the fact that half of the food products that are sold and consumed are of unusable quality, and 50 percent of the people drink poisoned water. Because of undernourishment, the energy resources of people have decreased by 25 percent in the last few years. The population's health depends to a level of 50 percent on socioeconomic status and only 8-10 percent on the public health system.

### Russian Academician on Rise in Tuberculosis

93WE0259K Moscow IZVESTIYA in Russian  
12 Feb 93 p 4

[Interview with Russian Academy of Medical Sciences Academician A. Khomenko, director of the Scientific Research Institute of Tuberculosis, by Lidiya Ivchenko; place and date of interview not given: "Tuberculosis Makes Itself Known Once Again"]

[Text] Ivchenko: Tuberculosis, which had once been proclaimed to be a disappearing disease, seems to have enjoyed a rebirth in recent years. Unfortunately mortality due to it is growing: While in 1989 there were 7.4 cases per 100,000 population in Russia, in 1991 there were 8.1. And although there are no data yet for 1992, they are certain at the Central Scientific Research Institute of Tuberculosis that the number is not going to go down.

This tendency is typical of not just our country alone. It has always been believed that tuberculosis is a disease of the poor, and a social problem. But medical personnel are

alarmed even in economically highly developed states: In the last 2 years the incidence of tuberculosis increased by 15 percent in the USA and England and by 12 percent in Switzerland, and the picture is not any better in France and Germany.

**Khomenko:** At first we tried to explain it in conjunction with growth of AIDS. Such an interrelationship does exist: After all, when the body is infected with HIV, it becomes defenseless, and the individual can die of any disease. But you can't explain it all just by the spread of AIDS. A certain cyclicity is apparently typical of every infection, and after many years of decline, the world is now experiencing this increase.

To add to this, tuberculosis agent has become more aggressive: Mortality is increasing because more serious forms of illness have appeared.

**Ivchenko:** The fact that tuberculosis is rampant everywhere, and not just in our country, is not much consolation. Is it true that our situation is probably worse because of social difficulties?

**Khomenko:** Our population's overall resistance to all diseases—not just tuberculosis—has declined. Nutrition has worsened, and as we know, a proper diet is the best medicine for a tuberculosis patient. A new category of inhabitants has come into being—refugees, and public health organs are simply unable to provide consistent preventive care to these enormous masses of refugees.

**Ivchenko:** Would I be right in saying that Moscow is probably a highly unfavorable city in this aspect?

**Khomenko:** Tuberculosis is growing in the capital as it is everywhere else, but its incidence is lower in Moscow, St. Petersburg, Voronezh and Ivanovo than in other regions. The average number of inhabitants falling ill in 27 of Russia's oblasts is 34 per 100,000—that's the overall indicator for the republic, but then we have averages of 54 in Kalmykiya, 60 in Khabarovsk, 62 in Chechen and 80 in Tuva. In some places this indicator is far above the statistical mean, partly due to settlement of former prisoners there: The prisons are also a major "supplier" of tuberculosis. High morbidity is documented in Western Siberia and in oblasts contiguous with Kazakhstan, where tuberculosis is widespread among farm animals. This is a general infection, and if milk from a sick animal is not boiled, people who drink it can fall ill. Our pasteurizing units are unable to destroy the tuberculosis bacillus; we have already been asking the agroindustrial complex for 10 years to create a technology which would ensure decontamination of milk.

**Ivchenko:** Still, what can we do in our conditions to bridle the growth of tuberculosis and reduce mortality due to it?

**Khomenko:** We need to provide medicines and vaccines to the population. And although BCG [not further identified] vaccine is only 80 percent effective against tuberculosis, immunizations are necessary. An "anti-immunization" campaign was recently waged in the press. In it, the authors of various articles cited the experience of developed countries, where BCG immunizations have supposedly been abandoned, suggesting that they are being offered only in our country and in Third World countries. But this is not so.

Preventive immunizations are regularly provided in Europe, while in the USA, some states offer them while others don't: There, the average morbidity is nine per 100,000 inhabitants, though in cities with a population above 300,000 this figure increases to 27, and in Harlem, the poorest district of New York, it is up to 72. On the other hand among persons of Southeast Asian descent it jumps to 300!

In our country, only two enterprises manufacture BCG vaccine—the Stavropol Bacterial Preparations Plant and Moscow's Institute of Epidemiology and Microbiology imeni N. F. Gamalei. They have their own problems, as a result of which interruptions in deliveries of the preparation often occur. Some time ago over a million newborn infants failed to receive immunizations against tuberculosis because of a shortage of vaccine.

Things are still worse with chemical preparations. Some vitally important medications are now being manufactured "abroad"—in Belarus and Ukraine. For example production of florimitsin, which used to be manufactured near Kiev, has been shut down completely—it's unprofitable, and none of our appeals and arguments will change anything. You can imagine how much hard currency we have parted with to purchase antituberculosis drugs abroad rather than making them ourselves.

Early diagnosis of disease is very important. The bulk of patients are revealed in ordinary hospitals, to which people go with their ailments and where they undergo careful examination. We need to reinstitute fluorographic examinations, which have fallen into neglect.

We need to seek ways to restore the treatment system that was destroyed over the last few years. The loss of health resorts in Crimea, built through the efforts of our former Union, has become an irretrievable one.

### Dysentery Cases at Psychiatric Hospital

93WE0192C Moscow MOSKOVSKAYA PRAVDA  
in Russian 27 Nov 92 p 1

[Article by Ye. Kiseleva: "Dysentery in No 15"]

[Text] A dysentery outbreak was registered in ward No 6 of Clinical Psychiatric Hospital No 15.

Epidemiologists revealed five patients and four bacteria carriers. In the opinion of public health physicians the outbreak began due to gross violations of hospital treatment, unsatisfactory diet, extreme overcrowding of wards, absence of an isolation ward and late hospitalization of patients. A recourse action amounting to several tens of thousands of rubles was taken against the hospital for its carelessness, and Mr. Gersimov, the chief physician, was personally fined R5,000.

### First Bone Marrow Transplants for Russian Children

93WE0160E Moscow VEK in Russian 11-18 Dec 92  
p 10

[Interview with Dr. Oleg Kryzhanovskiy by Lyudmila Shikanova and Vladimir Gubarev; place and date not

given: "The Condemned Are Beginning to Live: First Bone Marrow Transplants Carried Out in Russia's Scientific Research Institute of Pediatric Hematology"]

[Text] The pain of our children: The editor's office of the newspaper VEK and the "NEKOS" Studio of Scientific Journalism are actively participating in the program "The Pain of Our Children." We pledge to provide information regularly in this weekly publication on the status of pediatric hematology, on the needs and problems of the Russian Scientific Research Institution of Pediatric Hematology and on the work of young scientists and researchers.

We are certain that Russia's business people will participate in developing this international program in whatever way they can. We will tell the story of the fate of rescued children, and of those who helped them surmount a terrible illness.

Watch for our articles!

This article was written by Lyudmila Shikanova and Vladimir Gubarev.

Unusual, almost fantastic things are happening at the end of Moscow's Leninskiy Prospekt!

The television and newspapers are abundant with appeals to compassionate individuals to collect a certain quantity of dollars, marks or francs in order to send a child for treatment to the USA, Germany or France, while here—at the Russian Scientific Research Institute of Pediatric Hematology—the same severe illnesses are treated free of charge.

Parents are prepared to pay any price to obtain consultation with a celebrity, while here, young doctors whose names are not at all known to us but who received a joyful reception at the largest Western clinics, because they have demonstrated their competency not with titles but by their deeds, receive, examine and treat youngsters here every day.

And it seems almost completely implausible: Parents are given rooms in the Salyut Hotel free of charge—they are paid for out of the M. Gorbachev Fund.

Generally distancing themselves from the political battles, these doctors and public officials, hematologists and financial experts, surgeons and entrepreneurs, clinical practitioners and bankers are joining together in order to save children afflicted by the most terrible illness of our times—leukosis, or simply speaking, cancer of the blood.

The first results are clear for everyone to see: Despite the numerous difficulties, medical workers of the Scientific Research Institute of Pediatric Hematology are at the "world level" in terms of the level of care provided to children. This is not boasting—it's reality: It is confirmed by the planet's most prominent hematologists, who established the European School of Hematology in Moscow.

Today we would like to relate events which once again appear fantastic under our conditions: A bone marrow transplant was conducted for the first time in Russia's Scientific Research Institute of Pediatric Hematology. A similar operation was carried out later on in Tokyo, at

Nikhonovskiy [transliteration] University. Oleg Kryzhanovskiy, a young doctor and one of the institute's leading specialists, has a most direct relationship to these operations.

As it turns out, both the patient in Moscow and the youngster cured in Tokyo were also called Oleg.

**VEK:** The classical question of journalism: Who are you?

**Kryzhanovskiy:** I'm a doctor. I came to understand long ago that in all countries, on all continents, "doctor" is a term with a very wide definition. It is not a profession, but a way of life. You can't be a doctor just from nine in the morning to nine in the evening, and then go home and be a daddy, a husband, a hobbyist or a lover. To be a doctor is to be a creature of destiny.

**VEK:** How old are you?

**Kryzhanovskiy:** Thirty. I've been working six years since graduating from the institute. Now I'm the director of the bone marrow transplant division of the Scientific Research Institute of Pediatric Hematology and Oncology.

**VEK:** Why did you join this institute?

**Kryzhanovskiy:** My teacher, Professor Rumyantsev, organized this institute. It was our dream to work together with persons of like mind, with friends who thought in a way different from official medicine.

**VEK:** In the two years, to what degree were you able to attain your ideas, your dreams?

**Kryzhanovskiy:** If you're talking about me personally, then in general, we haven't accomplished anything yet. We are only just beginning. My personal objective centers on a group of patients within a very narrow range. Not the bulk of the patients, to whom we can provide real assistance and a cure in 70 out of 100 cases. My objective centers precisely on the remaining 30 percent, who are considered to be incurable today. This is a "worst case scenario," since this work is the most expensive and laborious, and the most thankless. But the goal is clear: saving a few more of the remaining 30 percent of the children. I am referring to bone marrow transplants, which in principle should be a routine matter. On the scale of Russia, the number of such patients is large—there are very many of them.

**VEK:** What are bone marrow transplants?

**Kryzhanovskiy:** They are a procedure that saves hopeless patients. For practical purposes it is very simple. Bone marrow is taken from a donor and transplanted into the patient (after very intensive radiation and chemotherapy, which essentially kills the patient's own bone marrow). The idea of transplantation is to combine the merits of chemotherapy and an immunological effect upon a tumor. By conditioning—that is, preparing—the patient with chemotherapy, we are in a sense able to "destroy" the malignant cells. Unfortunately healthy cells die as well. And if transplantation is not carried out, the child is unable to live. Bone marrow, you see, doesn't regenerate. Bone marrow comes to the rescue in view of the fact that healthy cells can fight any

malignant cells remaining, for practical purposes supplementing chemotherapy. In general, the mechanism of action is unusually complex, and many factors are involved. What is produced as a result is essentially a chimera—that is, the person carries two types of tissue within himself: his own and the donor's.

**VEK:** But what about medical ethics? I am referring to the main principle, "Do no harm!" Isn't it true that first you make it worse for the person, placing him at the brink of death, and then try to save him?

**Kryzhanovskiy:** If we are talking about transplantation as a means of fighting malignant formations, there is no other way. Unfortunately, this is the sole means of treatment for a large number of diseases.

**VEK:** When was the first time you were exposed to this?

**Kryzhanovskiy:** To the need for treatment—here, but as for precisely how to conduct the treatment—in Austria. Work with children, you see, requires a special system, which was nonexistent here. Transplantation was carried out only on adults, and moreover, these were isolated cases. In the clinic in Vienna I saw how treatment of children is organized on an assembly line basis. And I saw how personnel specially trained to provide specifically this form of treatment work.

**VEK:** What allowed you to take the risk of carrying out such transplantation at your institute?

**Kryzhanovskiy:** We brought back all of the expendable materials, and we were familiar with the procedure. In general, this was "piece-work"—we were capable of doing it, but we needed to establish a service that would allow us to make transplant operations routine. So we clenched our teeth, and did it! This is something that must be done on a continual basis. We carried out transplants in order to prove that we can do it, not to others but to ourselves! And to gain a realistic impression of what difficulties we would have—what needed to be changed, and what problems would arise under our specific, local conditions. From my point of view, training of the nurses became the most important task. A team had to be hammered together.

**VEK:** And what did the surgery show?

**Kryzhanovskiy:** That given a certain application of effort, we can do the job. The young nurses managed to carry out their duties in an outstanding manner, even though they are both poorly trained and poorly paid, and the working conditions are awful. Nonetheless, they were all simply infected by the success of the transplantation, and moreover, this was something they wanted to keep on doing in the future.

**VEK:** How did you choose your patient?

**Kryzhanovskiy:** It was hard to decide. In our first transplantation, the child was in remission—that is, he was feeling good at the moment. The first, very difficult stage of treatment was already history, and the parents had relaxed somewhat. Here we had a child that was walking, playing, and going to school, and we were suggesting putting him in the hospital.

**VEK:** Who was he?

**Kryzhanovskiy:** Oleg Kondakov. He is now eight years old. His mother is a nurse. And although there is another child in the family, he was not a suitable donor. Oleg did not have a donor, and therefore we transplanted his own bone marrow. That is, first we removed it from Oleg, and then subjected him to powerful chemotherapy, lethal essentially, if bone marrow isn't subsequently returned. It was a very serious situation; moreover we must not forget that even in the very good foreign centers, mortality reaches up to 10 percent. It is associated with the procedure itself. But Oleg's medical indications clearly suggested that he needed transplantation. We all tried to explain to the mother, without concealing anything, that we were doing this for the first time, that a risk existed, and that it was very great. We spoke with the mother and father several times, concealing nothing from them. We also talked with Oleg himself. By the way, psychologists kept him (and us as well, in my opinion!) under very careful observation. All of the preparations, including repairs on the room in the clinic, took around a month.

**VEK:** How long did the operation itself take?

**Kryzhanovskiy:** A month. The patient remains isolated for a month. The idea is to carry out the entire treatment cycle under special sterile conditions. This is a special service. The first week consists of chemotherapy, very powerful. Then the transplantation. And after the bone marrow is infused and the body begins working, the patient is nursed back to health.

**VEK:** Can you now guarantee total treatment success?

**Kryzhanovskiy:** I can confidently say that the transplantation ended favorably. It cannot be asserted that Oleg has recovered completely, but the course of treatment has ended, and everything that could be done for him at the modern level of medicine has been done.

**VEK:** Are you preparing for the next operation?

**Kryzhanovskiy:** Unfortunately that's impossible, because we don't have the money. By the way, one of the results of the first transplantation was that we calculated how much it cost under our conditions. It was expensive, but much cheaper than in the West.

**VEK:** Is it true that you carried out the next transplantation in Tokyo?

**Kryzhanovskiy:** That patient was also named Oleg. By the way, he had the same form of leukemia as did the first Oleg, except that this time there was a donor. His nine-year-old sister. And the operation was 100 percent indicated for the patient; it was his only chance, and it was a guaranteed one at that, if of course the operation proceeded normally. Unfortunately, we were unable to carry it out here. The idea of conducting the operation abroad had its inception a year previously, and it was only now that the real possibility for one appeared. The director of the hematological group in Tokyo invited us. We had become acquainted in Leningrad. He's a student of Doctor Robert Gayle. Doctor Mugishima visited our institute together with Gayle. They carefully looked everything over, and we had a long discussion of

various problems. Robert Gayle thinks in a very non-standard way, and he is well acquainted with the problem of transplantation in the world. He said: "If you want to carry out a transplantation, do it!" We came right back with objections, that one thing or another was unavailable to us, that we lacked drugs and equipment. "And you don't need any of that," Gayle said, "do what's within your means."

**VEK:** Are you saying that a "cheap" operation was carried out in Moscow, and an "expensive" one in Tokyo? Do I understand you correctly?

**Kryzhanovskiy:** Generally, yes. Doctor Mugishima worked three years in Los Angeles, after which he returned to Tokyo, where he is now working in a hospital. He has his own hematological group, but he only has one bed for transplants. However, he has carried out 50 transplant operations in five years! Without a single death. I am telling you this because it is very important to understand that it took tremendous courage on Doctor Mugishima's part to accept our patient. He was risking everything, primarily his own reputation. He organized absolutely everything: He sent money, found a sponsor, persuaded his associates, and provided for our stay there, even though not only the sick child but also his mother and sister traveled to Tokyo. One of Japan's trading companies allocated a considerable amount of money in order to make the transplant operation for the Russian boy possible and to allow a Russian doctor to participate in the operation.

**VEK:** What does your clinic need to go over to "assembly line" operation?

**Kryzhanovskiy:** What we have right now is desire and the medical personnel. What we lack are trained nurses and we have practically no material resources. When it comes to one-time expenditures, they're obvious: for a building, for equipment, for special isolation wards, and for a laboratory. But it should be kept in mind that all of that is followed by transplantation, which means expenditure of pharmaceuticals, treatment, rehabilitation and so on. This is a very large amount of money.

**VEK:** Is its absence the only thing that is holding back development of pediatric hematology in Russia today?

**Kryzhanovskiy:** Yes.

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At this point I stopped taping my interview with Oleg Kryzhanovskiy, although the conversation continued for some time longer. It was joined a little later by the directors of the Scientific Research Institute of Pediatric Hematology, professors A. Rumyantsev and Ye. Vladimirskaia. Naturally we discussed the problems of the institute and the difficulties the hematologists were experiencing. Ultimately we agreed that they would prepare a list of the necessary materials, instruments and pharmaceuticals without which they cannot begin a series of transplants: There are 16 sick children awaiting this operation today just in the department headed by Oleg Kryzhanovskiy. This list will be published in one of the next issues of VEK. I am certain that entrepreneurs and business people who could come to the

aid of the sick children will be found, since after all, their pain is the pain of all of our children.

### Who's Helping

- The initial contribution of \$100,000 by R. M. Gorbacheva was used to purchase pharmaceuticals needed on priority, as well as diagnostic and other equipment.
- Twenty doctors and three nurses underwent apprenticeship in German, Austrian and French clinics.
- The government of Nordrhein-Westfalen Land decided to pay for the practical training of 50 doctors from Russia, Ukraine and Belarus for a period of one year in clinics of this land. Upon completion of his apprenticeship, each doctor will receive assistance amounting to 5,000 marks to purchase medical literature and pharmaceuticals.
- The German entrepreneur Hubertus Vald donated 500,000 marks for the acquisition of pharmaceuticals, drugs and medical equipment.
- An agreement between the Senate of Berlin and the government of Moscow on cooperation in the treatment of children with oncological-hematological diseases is being prepared for signature.
- In spring, a bone marrow transplant division for children, the first in the former USSR, will open in the Scientific Research Institute of Pediatric Hematology. It will take \$2 million to set it up. Half of the amount necessary for the purchase of equipment manufactured by Germany's STEAG is being provided by the Gorbachev Fund—assets collected during M. Gorbachev's trip to the USA, and by the Dutch public official Fred Matser [transliteration].
- A study session of the European School of Hematologists was conducted at the Russkoye Pole Boarding Hotel near Moscow. Three hundred doctors took part in it. Lectures were given by prominent specialists from the USA, France, Austria, Israel, Germany, England and Russia.
- A number of American scientific centers in the field of hematology and oncology will accept specialists from Russia studying the latest accomplishments and conducting joint research for apprenticeships for a period of up to 1 year. This program could be expanded significantly if more money is found.

### Kirghiz Stomatological Polyclinic

93WE0160D Bishkek SLOVO KYRGYZSTANA  
in Russian 22 Apr 92 p 3

[Article: "Experimenting on Teeth"]

[Text] Our medicine, derided and cursed, but so necessary to us, the clients, visitors and patients, is taking its first creaky, uncertain steps toward the market, apprehensively, and virtually as if in great secrecy. Even here, the words "steps" and "toward the market" are a little too bold. Medical personnel are experimenting timidly; for some reason that they are shy about any publicity regarding this experiment. Perhaps they feel that it would be taken the wrong way.

After paid treatment was introduced, things became a little simpler in the Republic Stomatological Polyclinic. The orthopedic department had been working under this system for a long time already, and independently somehow from the others. Because without cost accounting, it couldn't survive: The wages of all of the nurses, child care providers, receptionists and cashiers depend on a special account to which money from patients is deposited. The only thing is that the rates jumped so high in the last half year that even the doctors are dumbfounded. The price of the simplest steel crown ranges from 12 rubles to 44. Plus 28 percent—that is, almost another third. And what if you want a gold tooth rather than a steel one? Well, first of all there has been no gold here since the beginning of the year, neither Tashkent nor Moscow has sent a single gram, and as for our own gold, which the press trumpets from time to time, the denture-makers have unfortunately never seen it with their own eyes. And secondly, a gram of gold now costs over a thousand rubles here. But even if someone wants the gold badly enough, the money could be dug up, were the material available. I'm certain the reader knows how painful teeth can be.

But in the therapeutic and surgical departments, paid service is something new, and it is being introduced very cautiously. In a shift, for example, two treating physicians work for money, while the rest work like in former socialist times—completely free of charge. And you get to choose. But you must understand that only physicians of the top category work for money, while those who work free of charge might not be as skilled. Which one do you choose? The one working for money. They are your teeth, after all!

Let's assume you need a filling, there's a hole in your tooth that aches all night and is threatening to become a real nightmare. A filling costs from 30 to 80 rubles. A sizable range, but a filling is not as simple a thing as it might appear: It, or more accurately the tooth in which it is to rest, possesses dozens of unique features. Moreover the filling material itself varies: I saw Czech and German material that has nothing in common with filling material made here. Which is why there is such a wide range in price.

A periodontitis treatment course costs on the order of R150, while extraction of a tooth under local anesthesia costs only 18.50. Of course, if various complications such as hemorrhaging arise as a result of extraction, you would need to add another 14 (that doesn't make sense: After all, if a complication could arise namely as a result of extraction, by logic the surgeon is the one who should be paying the unfortunate patient).

For the sake of justice it must be said that medical personnel at the Republic Stomatological Polyclinic have not gotten rich from introduction of market relations.

"They haven't gotten a kopeck from this experiment," said K. K. Kozhobekova, the deputy chief physician for therapeutic work, "while the wages of our physicians average R600, those of nurses average R460, and those of orderlies are still lower. Right now all we are doing is experimenting. We do not make it a requirement that anyone has to make use of paid treatment, and most patients from outside the

city get free treatment. And our physicians are all good ones; however, human psychology is such that it seems as if paying for dental service somehow provides better assurance that your teeth will remain healthy. Without the pain accompanying the treatment."

Paid medicine is living and developing in all the world without any of the complexes that are characteristic of only us, the Soviet people. We are a little too shy.

**Russian Toxicology Center 'Intotsentr'**

93WE0160B Moscow *PRAVDA* in Russian 3 Sep 92 p 2

[Article by O. Volkov and V. Nedogonov: "New Poisons in the CIS"]

[Text] With what did we poison ourselves in the times of stagnation? According to the assertions of toxicologists, brake fluid and methanol. Ordinary concentrated acetic acid takes 3,000 lives away yearly just in Russia. Each year we lose a total of 50,000 to poisonings. It is our country that has the greatest frequency of deaths by carbon monoxide poisoning in the victim's own garage. All-union standardization of bottles created a great number of woes: There have been times when a gracious host has gone to his storeroom to return with a bottle of wood stain for his guests instead of flavored vodka. When a party is going on, how can you possibly differentiate what's what in the same kinds of bottles?

Every country of the world, by the way, has its own poisoning specialty. In the States for example, mountains of aspirin tablets are swallowed, while in Bulgaria, quinine poisoning is the rule.

The rest of the world fed information on all known poisons into a computer and established an emergency consultation service long, long ago. We began creating such a service just a few years ago, when suddenly it became clear that all of the emergency wards were filled to almost half with poisoning victims, and no one knew how to treat them.

It was precisely then that \$25,000 to purchase a multi-channel chromatograph from the USA to determine the chemical composition of poisons were allocated to the First Aid Institute imeni Sklifosovskiy by a decision of the Russian government. Together with associates who were also toxicologists, Doctor of Medical Sciences V. Dagayev, who had collected information on poisonings for 20 years, established an organizational and research center for the protection of health from the harmful effects of the environment and from acute chemical poisonings—"Intotsentr."

It was revealed as a result that we have started to poison ourselves more frequently and by more diverse means. Having broken through to a state of commercial abundance, the people have raided their medicine chests and are using everything that they can get their hands on. Mastic is rubbed on at night like balsam, cockroach bait is used as shampoo, and people are drinking one part methanol to one part tea and pretending it's French cognac. Children drink tetraethyl lead (used to increase the octane rating of automotive fuel), while adults put themselves into a stupor by handling imported Colorado beetle poison.

The deeper we dig into the labyrinth of market relations, the higher the probability of passage to that other world. Now that the prices of pharmaceuticals have been lowered, complex alcohol extracts have appeared in the stores. In three months 800 persons tried just the preparation Foksim alone (80 percent alcohol). Forty of them have already died. We have started going to the market for herbal infusions more frequently (evidently there is no money for expensive pharmaceuticals), and the first lethal outcomes have already appeared. With food being so expensive, people are forced to seek sustenance beneath their feet—and immediately an outbreak of mushroom poisonings occurs in Voronezh.

Intotsentr's telephone rings incessantly night and day. Its computers contain information on tens of thousands of poisons (and in the future there will be 350,000 of them). The toxicologists are ready to analyze the entire diversity of products making their appearance in CIS countries, and they are capable of issuing fitness certificates for any goods and writing warning labels: What to do if you ate more than is permissible. That is, to do the kind of things that are already well known throughout the world. A document titled "London Principles of Information Exchange on Chemicals in Free Trade" has been requiring every selling country to provide the fullest possible information on the safety of its goods since ages ago. And it is only for the CIS countries that such "London Principles" have apparently not been written.

And perhaps they might never be written. Because on any given day, Intotsentr's telephones might fall silent forever. Assets allocated by the Soros Fund and the Russian Academy of Sciences ran out long ago. All that remains for the general director of Intotsentr to do is write desperate letters to the mayor of Moscow asking for money and at least some sort of space.

K. Ilyashenko, the senior scientific associate of the Moscow city center for acute poisoning treatment, noted: Cases in which patients with acute poisonings wind up at first aid stations after improper treatment in cooperatives have grown more frequent. Cases of poisoning by Royal brand alcohol and even by bulk port (someone came up with the idea of mixing cauterizing alkalis into all of these beverages) have already been recorded. We are threatened by salmonellosis in eggs, and pathogenic microbes proliferate in large numbers in sour cream stored in a hot environment.

Doctors expect that with the onset of winter frosts, the number of poisonings might decrease somewhat. But a new woe is already becoming clearly evident: We have become more nervous, and we are drinking down more sedatives and sleeping pills.

The impression is that the entire CIS would like to drop into a long, troubled sleep.

**Pharmaceuticals Reappear in Moscow**

93WE0160A Moscow *PRAVDA* in Russian 17 Dec 92 p 2

[Article by Valentina Proskurina: "Drugs. Ever Harder to Survive"]

[Text] A rumor that drugs have appeared in pharmacies swept through Moscow.

Many associated this with the activity of the Moscow Pharmaceutical Chamber, by elevation of pharmacies to the rank of municipal organizations. And it wouldn't be too long before they are privatized!

But the joy disappeared quickly as patients crossed the pharmacy thresholds. An old man reading the price tag on a box of a widely used cardiac agent thought he was having a bad dream—R1.05.

"One hundred five rubles," the cashier read the price off dispassionately. A convulsive sigh, and a trembling hand went into the pocket for a wallet. What can you do? You could do without bread. But without medicine—death. It would be useless to go to another pharmacy. It would be no less expensive there. His Highness Monopoly is operating. By the way, if we consider that the availability of cardiovascular drugs decreased this year to 42 percent of demand, we can only be amazed that we aren't paying a thousand for a package.

By the way, there are also drugs with three zeros on their price tag. American aspirin for example. So where is our aspirin, that which we used to buy for kopecks?

The difficulties involve not only cardiovascular drugs. We have only 58 percent of the needed oncological drugs, and 32 percent of psychotropic drugs. There's not enough insulin, there are no anthelmintic preparations. This list could be lengthened all the way to manganic salt, activated charcoal and mustard plasters.

All of this is evidence of an extremely deep crisis in pharmaceutical industry. All of the plants look as if they have been devastated by some natural disaster. High purity, high precision production operations are located in buildings where the roofs leak, and wind whistles through broken windows. Many new ones aren't being built—no one needs ineffective production operations that pollute the air, seeing that our production processes have fallen a good 30 years behind the world level!

#### Prices of Pharmaceuticals in Pharmacy No 126 (Leningradskiy Prospekt, 13) as of 14 December

Analgin	19.50
Citramon	39.00
Fenkarol	74.00
Paracetamol	30.00
Kholosas	91.00
Mogadon (sedative)	522.00
Aspirin, imported	624.00
Alupent (for asthma)	1,975.00
Catapresan (for hypertension)	1,360.00
Strepsils (for angina)	1,900.00
Disposable syringe, 10 ml	58.00
Nonsterile dressing	50.00
Leukoplast, bactericidal	11.00

To be honest, these problems are not new. The former government did everything according to plan: It allocated the currency to buy the pharmaceuticals, and it built the latest plants in CEMA countries, which supplied us regularly with modern drugs. But there was one thing they didn't plan for—CEMA's disintegration. As a result we were left out in the cold.

What can we do? Is there a solution? Many medical workers feel that the idea of building a supergiant producing modern pharmaceuticals in Russia is unrealistic and unnecessary. It would seem that gigantomania is a stage that is now in the past. How many years would it take to erect such a plant? The most realistic thing to do would be to rebuild. Were we to obtain the principal ingredients from the West, our industrialists could themselves manage with the fillers and the packaging. This is much cheaper than purchasing ready-to-use forms, or ourselves "reinventing the wheel." None of this discussion is new, but who is listening?

The root of all of the misfortune obviously lies in the fact that in our country, pharmaceutical programs do not enjoy the priority they do in other countries. The government is embarrassed when it is called antipopular. But how do we reckon with the fact that for the first time, mortality has exceeded the birth rate in our country? There are many causes, but pharmaceutical industry doubtlessly shares some of the blame as well.

"We filled the stores with goods," the former head of our government said proudly at a congress.

What's true is true. The windows of what used to be newspaper kiosks now sparkle with the labels of transoceanic wines, and the bright wrappings of chocolates and "children's surprise packages," inaccessible to most children, glisten.

And without a doubt, the shelves of the pharmacies will also fill up. By the same principle as for the shelves of commercial stores: Goods visibly displayed attract customers. But in the meantime a little boy dies in a pediatric hospital bed—he lacked the dollar for an ampule of medicine that would have saved his life.

#### Tajikistan Health Resorts Founder

93WE0163A Dushanbe NARODNAYA GAZETA  
in Russian 3 Jul 92 p 2

[Article by A. Pal: "In the Bankruptcy Zone: That's Where the Republic's Health Resorts Are"]

[Text] Reading the advertising page of the newspaper, I came across an ad selling passes to the Khodzhaobigarm health resort and Shaambary sanatorium. I was of course amazed by the prices—R2,800 to R4,200, but I was happy for the Obigarm resort: Its passes had all been sold out in these gloomy times even without advertising. But as it turns out, everything is the reverse, like in a nightmare: This veteran health resort—it's half a century old—is under the threat of closure. A victim of the market?

Of course, we can't forget about the market for a single minute: It's speculative, merciless wheel grinds down everything. The only thing is, in what market in the world can you find health for sale? Understandably in today's economic situation the health resorts and institutions like them are the first to feel the blows, unless of course they reduce themselves to doing a commercial strip tease.

The Obigarm resort began its season at around 10 percent of its capacity. Naturally its administration became concerned, and so it turned to the Republic Council for Management of Trade Union Health Resorts, which has to contend with many other resorts besides Obigarm. What possibilities did they have before them? They could visit different rayons in their own republic and neighboring Uzbekistan, where Tajik health resorts are popular. So they went. Before, distribution of passes was completely the job of the health resort council's sales department, and the institution itself sold them for R20-30, but even this was undesirable. Now even the doctors have to make the rounds of Dushanbe's enterprises selling the passes. But the result has been negligible.

The state of sanatorium and health resort services to laborers is reflected in an official letter sent by the council to the Trade Union Federation, the Cabinet of Ministers and the republic's Supreme Soviet. In the middle of June, there were 1,344 vacancies (69.5 percent) in sanatoriums and health resorts, and almost all rooms were vacant in vacation homes and boarding hotels: Only three persons (!?) were vacationing in the Karatag. The vacation homes Yavroz and Kanibadam did not open at all. The pass sales figures were 20.7 percent for the second quarter and 14.8 percent for the third. Pass sales are down on the order of R8 million.

Therefore when on 25 May the administration of Obigarm wrote the council for help, it received its reply on the same day: "...implement measures directed at temporarily closing down the health resort from the first of August 1992 to 1 May 1993." This reply was a forced one, as they say. An order "to stop (close) the health resort" was dated with the same date. The order goes on to require that the administration seek additional financing sources in accordance with the new personnel roster listing "service personnel for the period of the health resort's shut-down." These sources include outpatient services, and the leasing of available transportation and waste treatment plants to one organization or another.

So that we needn't return to this issue, let me say right away that the proposed financing sources do not seem at all realistic. There are medical institutions here that provide services to patients, and anyway, part of the health resort's personnel have already obtained jobs there, if they haven't moved away altogether. The motor transportation is worn out, and there is very little of it. And as for treatment plants, the health resort itself requires services of Rogungesstroy [not further identified], as it does for water and electricity. Moreover there are no organizations of any significant size in Obigarm that could lease the waste treatment facilities.

But that's not the problem: Once the head is severed, no one weeps for the hair. Closing of the resort, even temporary, would mean its devastation, its liquidation. And later on, it

will take millions to replace all that will be pilfered, and possibly sold on the cheap. No matter with whom you talk, everyone has the same opinion—the health resort mustn't be closed. Still, our people are of a good sort. No matter how the well off try to subordinate everything in life to the power of money, and measure human values only by their monetary worth, our people are concerned primarily with the individual, with his pains and his hopes.

"We provide treatment for osteochondrosis of varying pathology using a laser device," said Sh. Radzhabov, a physician and a laboratory technician. This is an effective method. Where else could patients obtain such treatment? Doctor A. Dadabayev feels like he had lived all of his life here. He certainly is aware of the therapeutic value of the local rhodonite springs. Moreover, he notes, the Obigarm resort has a number of advantages over the others: The climate is fabulous here, and the mountain air is as pure as it can get. People in relation to whom Khodzhaobigarm is contraindicated because of the altitude could undergo treatment here. Only the Obigarm offers underwater traction and a mud therapy procedure to treat infertility, emphasizes Doctor E. Offengenden.

Gardener M. Olimov and equipment mechanic Z. Pirov couldn't talk about the health resort's fate unemotionally: Without a reliable caretaker, the heating system and the boiler room would stop working, and the furniture and equipment would be ruined. Evidence of this can be found in the Rogungesstroy dormitories next door: Left absolutely vacant after undergoing overhaul, they now look like something after a battle—even the doors and window frames are gone.

And where are more than a hundred of the health resort's associates to find work in Obigarm or Rogun! Must they undergo retraining? In what? Should they become entrepreneurs? What sort, if they already have something that is so very much needed by the people—health treatment?

At the health resort I met with Professor M. Bobokhodzhayev. On hearing the news, the professor, who had himself worked here some time ago, was unable to comprehend such a thing. No, the professor repeated again and again, the health resort must be saved.

Naturally I also asked some of the patients: What was their opinion of the fate of the Obigarm?

I. Avazov from Yavanskiy Rayon:

"Consider how many patients, old people and pensioners have visited the resort during its years of operation. This is my third time here. I was having headaches and my legs hurt. But now I feel better. While the resort shouldn't be closed, it shouldn't be turned into a cooperative either."

A. Rasulov, a teacher from Yavan:

"This is my first visit here. I've been in the Caucasus, but I liked the Obigarm more. Today, it's impossible to travel anywhere for treatment—it's too expensive. And as for closing one of the republic's own health resorts? The government should make another decision that would be acceptable to the people."

**U. Tukhtayev, a blacksmith from Bukhara Oblast:**

"When I fell ill, I could no longer sit, even in the way we are accustomed to sitting here by tradition, but now, as you can see, I am sitting, and I feel very good. This is my fourth visit here as a result. Where I live, it's now hot and dusty, and to lose the possibility for visiting such a paradise would be a shame—it would be perestroyka to the detriment of the people."

**N. Rakhmatov, a war and labor veteran with group two disability:**

"Treatment at the health resort has become very expensive—beyond the means of pensioners, laborers and many people in our society. We need to lower the prices of the passes, and do away with the unnecessary taxes. Commercialization of the health resort would turn it into a pleasure palace. The Obigarm should remain exactly what it is, a patient treatment center. By their labor, all of these people have earned the right to the resort."

(At this moment a proponent of the market came running up to us and entered into a tirade without introducing himself: "What are you talking about here? What sort of correspondent are you? This is the time of the market. The entrepreneur is the most important thing. The market exists now, and it is everything." He was absolutely ignored. When he finished, he left as quickly as he came.)

**A. Eshmomenov, a teacher from Kabodiyenskiy Rayon.**

"This is my fourth visit since 1969. Before, there used to be many visitors from Russia in the Obigarm, and I was happy that my Tajikistan was helping sick people from far away. But now, you can see for yourself: Things are going against the resort.

"I heard that some people are considering leasing the resort, but then, entry to laborers would be closed. What could our trade unions do in such a case? The health resort must remain a republic state institution. And the price of the passes must be lowered."

**I. Grinshpan, a pensioner from Dushanbe:**

"I was completely crippled by radiculitis when I came here the first time. This is now my fifth visit. Treatment at the health resort helped me to continue being a useful member of the society: I used to work as an electrician. You can't close the resort or turn it over to private hands."

My interviews on the status of sanatorium and health resort services to laborers reached their conclusion at the Tajikistan Republic Trade Union Federation. It's too bad of course that R. R. Akhmedova, the deputy chairman, found more important things to do than discuss this issue. Even though I had made an appointment beforehand.

Beginning the discussion, M. Yusufdzhanyov, director of the state social insurance department, explained that social insurance deductions were a very small percentage in the

republic—15 (for comparison, in Kazakhstan for example it is equal to 19.5 percent). The total receipts of 47 [digit illegible] million rubles anticipated from these deductions are not enough to cover expenses. This is despite the fact that the republic has completely rejected passes to what used to be called central health resorts, and cut passes to its own resorts by half. After subsidies from the central (all-union) council were done away with, the republic council found itself threatened by bankruptcy.

"First of all I would like to stress quite clearly," said Ibragim Samadovich Radzhabov, chairman of the council for management of trade union health resorts, "that our goal is not to close the health resorts, but if we don't get the money we need, we will go bankrupt. By economizing in every way it can, the council will be able to go on independently until November of this year. Sanatorium and health resort institutions have to deal with double taxation. Many times we have raised the issue of repealing value-added tax and tax on profit from the services of public health institutions, and of granting exemptions, so that the cost of passes could be cut by R650-700 and investments into the sector could be maintained at least at a minimum level. But no decisions have been made."

And it is everything, and not just the Obigarm, that is falling into disuse. There is an immediate need for overhauling the grounds of the waste treatment plants at the Shaambary, for reroofing the main buildings of the Khodzhaobigarm, for making emergency repairs in the Ura-Tyube, Khavatag and the same Obigarm sanatoriums, and for finishing construction of the balneotherapeutic facilities of the Kaltucha. And much, much more! There is no money for this. While repairs are now 10 times more expensive, money is being allocated for this in the former amounts.

The question of the causes of such a disastrous position of the sanatorium and health resort sector came up everywhere I went, and the answers to it were astoundingly unanimous: the country's disintegration, as one of my interviewees said, into the commonwealth of impoverished states;

the unstable political situation in the republics; skyrocketing prices—of passes, of transportation, coupled with a concurrent worsening of quality in all things; absence of any privileges for the sector.

It is of course impossible to comment in any way on what we have seen, heard and read—everything speaks for itself. But we shouldn't fall into despair either. Still, the sector is dying. For the thousand and first time, the economists, public officials and the simple laborers and peasants who spoke out against liberalization of prices were right: Because of this, the sanatoriums and health resorts have now become unavailable to those who need them, as is true for the entire system of social support of the people.

How are we to pull the sanatorium and health resort sector out of the bankruptcy zone?

## IRELAND

### Increase in TB Noted Among World's Highest

93WE0299 Dublin *IRISH INDEPENDENT* in English  
28 Jan 93 p 13

[Article by Eilish O'Regan]

[Text] Ireland ranks among the European countries with the highest percentage increase in the notification of TB cases, a new report from the world Health Organization (WHO) reveals.

The notification rate went up 18 percent between 1988-90, while top of the league was Switzerland at 33.33 percent followed by Denmark, Italy and Norway.

A committee set up by the Department of Health is currently looking at methods of treatment and administration of the disease in this country.

The WHO said that increasingly TB is becoming a socio-economic disease, which hits the underprivileged hardest in both developed and developing countries.

Up to the mid-1980s, TB cases in industrialized countries were declining but because of the success of the national programs public funds for TB control are being curtailed.

The reversal of the trend in the United States appeared in 1986 and AIDS has been playing a major role in the upswing of the disease.

In Europe, the causes are much more diverse and the increases are occurring mostly among the foreign-born.

In England and Wales, immigrants and residents from the Indian subcontinent have a high incidence of TB, while in Scotland and Northern Ireland the previous decline in TB stopped. The developments do not appear to be HIV related.

"Today there are clear signs that the disease, once on the verge of elimination, in Western Europe and the United States, is making a powerful comeback," the report states.

TB claims more than 3 million lives worldwide every year and more than 8 million new cases develop annually.

## ITALY

### Laboratory Robot Developed for Diagnoses

93MI0313 Milan *GENTE MONEY* in Italian Feb 93  
pp 88-89

[Article by Emilio Torredimare: "Their Robot Discovers Allergies"]

[Excerpts] How to make money from pollens, dust, animal hairs, wool, and serums, or in other words, from an army of allergies waiting to attack from common hay fever to skin rashes, from asthma to the highly dangerous anaphylactic shock. Bioallergy, a small company in Trieste, is trying to do just that and has had the courage to challenge the monopoly of a multinational Swedish giant. It is doing so with a secret weapon which has put the competition on the run and which everybody is trying to copy. Efficient New Enzymatic Allergy System (ENEA) is a mini-robot, the only machine in

the world to completely automate test-tube dosages for the laboratory diagnosis of allergies.

The fact is that probably nobody is completely immune from allergies and so the number of subjects involved makes this a very profitable business. Therefore, any company which is able to corner the diagnostic market for the determination of the cause of an allergy can count on a large-scale worldwide business.

Up until 1989, that privilege was locked up in the patents office of Kabi-Pharmacia, a company belonging to the Swedish multinational Procordia, which has held the sole rights for 20 years. Now, two small-timers, Simonetta Cosimi and Nevio Recinelli—both vice presidents of their company Bioallergy International—are challenging the giant through the placing of one ENEA after another: in 70 out of the 250 hospitals in Italy which have allergy departments, 35 percent of the analytical laboratory market. In addition, the first aggressive moves away from home have also been made in Spain, France, and Germany, and even as far as the Swedish wolf's den: The hospital at Upsala, the city where Kabi-Pharmacia has its headquarters which, while continuing to use the company's system, has asked to take an ENEA on trial.

### ENEA's Beginnings

Everything started at the beginning of 1987 in the offices of Importex Pharmaceutical Chemists in Trieste, a company affiliated with Don Baxter Laboratories, the American pharmaceutical colossus. Nevio Recinelli had gained all his experience there, working for the group for more than 19 years and at the time he was sales director. Simonetta Cosimi instead, was a young researcher who had finished university four years before and had come to work as a product manager in the diagnostics division. In other words, she knew all the technical secrets of allergology. [passage omitted]

In February 1987, these two decided to go into business on their own and months of hard work resulted in the creation of their company, Bioallergy, by the end of the year. To start with, it was merely a commercial concern doing the same thing as Don Baxter that is, distributing material for allergy diagnosis. [passage omitted]

### A 600-Million-Lire Investment

In the meantime, with Bioallergy serving as the basis for getting started, making money, and creating a structure, the main project for a machine which could do everything went ahead. Between the end of 1989 and the beginning of 1990, the business plan was ready. Principally, the designers had put together the first prototype of the automated diagnostic system together with the specific reagents which it would use. The total cost of the project was around 600 million lire. Results were immediately outstanding. Without the presence of an operator, the machine was able to carry out 450 tests for 30 patients in four hours, against the 180 tests for 30 patients in the six and a half hours of a nonautomated system. For a big hospital, that meant testing at least 60 patients a day, or even more, seeing that the machine can work unsupervised at night, and print out the results the

next morning. What is more the tests performed were 10 times more precise than traditional tests.

At that point, everything was ready. All that was needed was a name for the machine and headquarters that would not be too expensive for the company's meagre resources. Since the mother company Bioallergy was based at Fiumicino in the so-called Isola Sacra area, the place where ENEA is said to have landed, the name had to be that of the Trojan hero. All that then needed to be done, was to invent an acronym to fit the name ENEA. No sooner said than done, and Efficient New Enzymatic Allergy System was coined. The major difficulty, however, was finding a suitable structure in which to establish the new company, Bioallergy International, which would produce the reagents and manage the ENEA patent.

#### Return to Trieste

The mountain which seemed unsurmountable was finally overcome with the help of the BIC (Business Innovation Center) of Trieste, a public organization for the promotion of technological enterprise. "Without BIC in fact," said Simonetta Cosimi, "we would never have been able to put the idea into operation. And for me there was also a personal factor involved, which was the opportunity to return to Trieste, my home town." At BIC, Bioallergy International found everything it needed to function: well-equipped areas, consultants, training, conference rooms, telephones and telefaxes, and assistance in finding financial backing. As a result, from December 1989 the new company was able to begin producing diagnostic materials exclusively for ENEA, which were then marketed by Bioallergy, the mother company in Rome. At present, the diagnostic robot is produced under license exclusively for Bioallergy International by an outside company but soon many ENEAs will be built by the company itself at its factory in Trieste.

This Friuli-based company, whose revenues came to 500 million lire in 1991, quadrupled its business by the end of 1992 to 2 billion lire. The forecasts predict a rapid growth: 6 billion lire for 1993 and 10 billion lire for the following year when the Bioallergy group should reach revenues of 28 billion lire with an expected profit of between 15 to 18 percent. In reality, the profits do not come from ENEA, a machine which costs 60 million lire and is lent free of charge to hospitals, but from the reagents which are necessary for its operation.

The prospect of an enticing world market has opened up for Bioallergy. "The new projects will not stop with ENEA," say the two vice presidents. "We are already planning a robot which will be even more versatile and innovative."

#### UNITED KINGDOM

**Health Service Hits Midyear Cash Crisis**  
93WE0203 London *THE DAILY TELEGRAPH*  
in English 12 Dec 92 p 5

[Article by David Fletcher]

[Excerpt] The health service has hit a mid-year financial crisis with scores of hospitals running out of money and

consultants being asked to cut their workload, the British Medical Association said yesterday.

A meeting of the BMA's consultants and specialists committee said that bed closures and cancelled operating sessions were widespread as cash ran out four months before the end of the financial year.

It said the NHS was increasingly developing into a two-tier service as a result of the Government health reforms; and it claimed patients were now being denied treatment unless they were registered with a budget-holding family doctor.

This is the first time the BMA has spoken out in such forthright terms since its unsuccessful campaign against the reforms more than two years ago.

It said in a statement that many hospitals had completed health authority contracts to treat patients well before the end of the financial year.

Because of this, there was no more money coming into the hospitals.

The statement added: "As a result, unless consultants agree to treat patients of GP fund-holders, some of these hospitals are effectively treating only emergencies."

Mr. John Chawner, a consultant gynaecologist and chairman of the committee, said the situation was "extremely disturbing."

He said he would bring it to the attention of Mrs. Bottomley, Health Secretary.

Mr. Chawner said: "There is a financial crisis with us now and it is likely to get worse. Nothing that has happened under the NHS reforms has provided more money for services."

There was something fundamentally wrong with a system which left three months of the year with work not being done.

He added: "It seems to me the Government has abandoned all pretence that there is not now a two-tier service, and consultants believe they are being asked to unethically promote a two-tier service.

"There appears to be a freeze on surgery in many parts of the country for patients of non-fund-holding GPs and this is unacceptable."

Hospital cutbacks have hit all parts of the country. At Winchester, Hants, operating time for consultants has been reduced by half because hospital contracts to treat patients have been fulfilled.

At Derby there is a ceiling on the number of operations consultants may carry out, while at Waltham Forest, east London, there have been staff redundancies and restrictions on non-urgent operations.

The Central Middlesex Hospital, north London, is closing some operating theatres for a month and deferring non-urgent operations. [Passage omitted]

## Statistics, Problems of Health Service Reviewed

### Health Department Reports

93WE0256A London *THE DAILY TELEGRAPH*  
in English 10 Feb 93 p 2

[Article by David Fletcher: "Nearly a Million Waiting on NHS Lists"]

[Text] The number of patients waiting for NHS hospital treatment rose to a record of nearly a million at the end of last year, Health Department figures showed yesterday.

The total, 976,769, was an increase of nearly four percent over the previous three months. Every health region showed an increase, ranging from nearly nine percent in North-East Thames to well under one percent in neighbouring North-West Thames.

Although waiting lists are longer, the time people wait is falling. Two-year waiting has been eliminated apart from 600 people on stand-by for specialist hospitals.

The main achievement is that those waiting between 12 months and two years have fallen by 10 percent, although those waiting up to 11 months have risen by just over five percent.

Mrs. Bottomley, Health Secretary, hailed the reduction in the number of people waiting for more than a year as a major success for the Government's health service reforms.

"The number of patients waiting over a year fell in 1992 by a remarkable 45 percent; by over 58,000. The number of patients waiting over a year at the end of December was the lowest figure ever recorded."

The figures show that the average period of time that patients spend waiting to get into hospital fell from nine months in March 1988 to five months last March.

Half of all people admitted to hospital have no wait at all. Of those who have to wait, four out of five are admitted within six months and nine out of 10 within a year.

"We are reducing waiting times and reducing them fast," said Mrs. Bottomley. "The increase in the number of under one year waiters reflects the fact that more patients are now being referred for treatment as the NHS works more effectively and is able to offer many more services."

She said that, in the first year of the NHS reforms, the service had treated seven percent more patients than in the previous year.

"This is not simply an arid statistic. For those half a million extra patients treated, it meant quicker treatment and an improvement in their quality of life."

### Health Trusts Survey

93WE0256B London *THE DAILY TELEGRAPH*  
in English 1 Feb 93 p 7

[Article by David Fletcher]

[Text] The health service has treated more patients this year, cut waiting times and spent more money than before, the National Association of Health Authorities and Trusts says today.

Its assessment, based on a survey of just over half of all health authorities, is in marked contrast with claims by the British Medical Association that the NHS is facing its worst crisis for 30 years.

Mrs. Bottomley, Health Secretary, described its findings as "positive and encouraging evidence of the healthy state of the NHS."

She said: "I commend this survey to any of the crisis-mongers who have been putting their views forward recently."

The survey says the Health Service's ability to increase patients treated is shown by the number of hospitals which have treated greater numbers than specified in their contracts with health authorities.

It admits this unexpectedly high level of treatment before the end of the financial year has caused problems. Some health authorities reduced or capped the treatment of non-emergency patients, a handful sought extra money by transferring cash from capital to revenue budgets and a few negotiated efficiency savings with hospitals.

Mr. Bill Darling, association chairman, said: "The survey demonstrates the NHS is not in crisis but there is no doubt that matching resources to activity is crucially important."

The survey finds that, after allowing for inflation, cash available for health spending has risen by 2.8 percent in the current year but it is estimated to rise by only 0.7 percent next year.

Mr. Darling said it would cause resources to be kept on a tight rein next year. The key challenge would be to match patients more effectively with available cash.

More than a third of health authorities renegotiated one or more contracts with hospitals this year. The most common reason was that more patients were being treated than specified in the contract.

"This overperformance of providers (i.e., hospitals) remains the key issue for most districts," it says.

The survey estimates that as many as 330,000 people will have been sent to hospital for treatment by the end of the year as "extra-contractual referrals"—meaning they were sent to a hospital which did not have a contract to treat them.

Almost one in five sent for non-urgent reasons was refused treatment initially but the survey found at least three-quarters were treated eventually, often at the hospital's expense.

The report says that extra-contractual referrals—a major point of friction in the new contracting system—form only a small proportion of the 7.5 million patients treated each year.

Commenting on the survey, Mrs. Bottomley said it was time to take sensible action which would improve the way health services were managed next year.

"District health authorities should be learning from GP fundholders and the ways in which they have often been able to manage their budget more effectively."

### Trust Hospitals Financing

93WE0256C London *THE DAILY TELEGRAPH*  
in English 2 Feb 93 p 4

[Article by David Fletcher: "Half of Trust Hospitals 'Refusing Routine Cases'"]

[Text] As many as half of all trust hospitals are now refusing patients with non-urgent conditions because they have treated more patients than expected in the first half of the year, it emerged yesterday.

The proportion of hospitals cancelling operations has grown steadily since it became apparent that two out of three hospitals have completed their contracts to treat patients within the first 10 months of the financial year.

Thousands of sufferers with non-urgent conditions such as varicose veins and hernias are now being put on waiting lists until April when next year's money starts to flow.

Mrs. Bottomley, Health Secretary, insists there is no crisis, but she is calling doctors' leaders to a meeting with Sir Duncan Nichol, NHS Chief Executive, and plans new guidance for NHS managers.

The national picture of cancelled operations and deliberate slow-down in the number of patients treated has been shown up by separate surveys by the National Association of Health Authorities and Trusts, and by the British Medical Association.

The survey in the British Medical Journal found that 26 out of 33 big hospitals have already treated more patients than they have been paid for. Nine have reduced activity to stay within budget and a further four may follow.

A third survey by the Today programme on Radio 4 found that more than half of a sample of 91 trust hospitals have cancelled operations or plan to do so before the end of the financial year. Mersey health region is virtually unaffected and the position in Wales is much less severe than in the South and East Anglia. The Thames health regions are among the worst affected.

In some areas, the cash shortage left beds empty. In others there is a shortage of beds for emergencies and urgent cases.

This is because at the beginning of the financial year hospitals planned to maximise bed use by having a high patient throughput. Consequently, they could not afford to keep many beds vacant in case of emergencies. But in several areas there has been an unexpected surge in urgent cases and emergencies.

Pressure on beds is particularly acute in London where doctors made more than 500 calls to the Emergency Beds Service last week trying to find places for seriously ill patients.

Many were elderly patients requiring urgent treatment, including those with heart failure and acute asthmatic attacks as well as those with appendicitis and hernias.

Mr. Graham Hayter, manager of the service which covers London and parts of the Home Counties, said all were eventually admitted to hospital but 150-30 percent—were found beds only because the service has power to force a hospital to take a patient even though it said it was full up.

He said: "We appreciate we are causing problems by requiring a hospital to take a patient because it means they have to create an empty bed by discharging another patient, cancelling a planned admission or moving patients from one ward to another."

Among hospitals affected are Forest Healthcare NHS Trust, Waltham Forest, (closing two wards), the Central Middlesex Hospital (120 staff made redundant), St. George's, Tooting (48 redundancies and 92 bed closures), and Frenchay Hospital, Bristol (closed to routine admissions except patients from GP fund-holders).

Major hospitals such as the John Radcliffe, Oxford, and Stoke Mandeville, Bucks, are reduced to taking only emergency patients until April while Northampton General is slowing down admission of non-urgent patients.

Mr. Hayter said doctors had great difficulty in finding beds for patients because in the drive for efficiency, hospitals were now run more intensively with higher patient turnover than in previous years.

He said: "They are now full virtually all the time and the lack of spare capacity means they do not have the flexibility to absorb unexpected demand."

The National Association of Health Authorities and Trusts agrees that many hospitals are on a financial knife edge—but says it is wrong to talk of a health service crisis.

Mr. Philip Hunt, the association director, said many hospitals were cutting back or even halting treatment of non-emergency patients because they had fulfilled their health authority contracts and had no more money to treat cases.

He said: "No one denies this is a problem. It is not the way we would have wanted it to happen, but you have to set it against the overall performance of the NHS this year."

"I have no doubt that end-of-year figures will show more patients have been treated and that inroads have been made into waiting times."

The BMA is so concerned that it wants a report from consultants on the situation in 1,000 hospitals as part of a survey to be published this month on the state of the NHS.

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